Capacity for Preferences and Pediatric Assent

Implications for Pediatric Practice

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Children's preferences about medical treatment—like the preferences of other patients—hold moral weight in decision-making that is independent of considerations of autonomy or best interests. In light of this understanding of the moral value of patient preferences, the American Academy of Pediatrics could strengthen the ethical foundation for its formal guidance on pediatric assent.

In the past thirty to forty years, clinicians and bioethicists have expanded the scope for children's participation in decision-making about their medical care, often under the banner of "pediatric assent."[1] The success of this movement was signaled perhaps most strongly by the creation of American Academy of Pediatrics (AAP) guidance on pediatric assent in 1995.[2] This document was revised in 2016 to further emphasize the importance of including children in medical decision-making, and it maintained the core arguments for assent and clinical guidance.[3]

There are many accounts of what pediatric assent means, some of which are only implicit in recommendations about how to involve children in their own care.[4] Maya Sabatello and colleagues observe that "pediatric assent" can name a set of practices along a continuum between two extremes.[5] At one end is full informed consent exercised by children. Some children are capable of informed consent and therefore have moral rights to participate in health care decision-making that are analogous to the moral rights of adult patients who possess decision-making capacity.[6] For example, David Wendler and Seema Shah effectively equate pediatric assent and informed consent, arguing that the grounding for the moral value of assent rests on autonomous decision-making, and therefore, at least in the context of research, assent should be available only to children age fourteen or older.[7] While there is continued disagreement about the ages at which children can provide informed consent,[8] debates about the decisional authority of children capable of informed consent have solidified around questions about children's

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neurological development[9] and parent's rights and responsibilities.[10] These are important debates, but in the interest of terminological parsimony, here we bracket and set aside this discourse as referring to children's informed consent rather than to pediatric assent.

At the other end of the continuum introduced by Sabatello et al. are conceptions of pediatric assent that treat the involvement of child patients in health care decision-making as merely a pragmatic means for avoiding conflict and for making health care team members "feel better, without truly empowering children to participate in decisions."[11] We acknowledge that there may be many useful strategies for generating the acquiescence of child patients, and we think that these strategies may be ethically justified, given the importance of children's compliance for the success of many pediatric interventions. But, following the AAP, we reserve the term "pediatric assent" for a *moral* ideal related to children's participation in health care decision-making, one that involves the cultivation of the child patient's awareness, understanding, and meaningful agreement with treatment.

The precise requirements of pediatric assent should be informed by what is developmentally appropriate for the individual child patient, and therefore different conceptions of pediatric assent lie along a spectrum between informed consent and acquiescence.[12] We focus on this expansive middle ground both because the decision-making capacity of most children falls in this range and because the moral value of nonautonomous children's participation cannot be based on the value of autonomy. This expansive middle ground is captured by the broad framework of pediatric assent embraced by the AAP in its 1995 statement and in its 2016 reaffirmations. According to the AAP guidelines, pediatric assent includes the following elements:

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(s).

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.[13]

A central component of the AAP's pediatric assent process is the solicitation of the preferences of child patients who lack decision-making capacity, that is, children who are not capable of informed consent. Both the solicitation of assent (4) and the determination whether children are under inappropriate pressure (3) aim at revealing patient preferences. We agree with the AAP that both the best interests of the child patient and the need to respect the child patient are reasons to take seriously children's treatment preferences. However, we argue that the AAP could provide a stronger and more stable ethical foundation for pediatric assent. Current policy documents invoke a conception of respect that is grounded in autonomy and that, therefore, cannot apply in most cases of pediatric assent. We argue instead that the mere fact that children have treatment preferences is a reason to support pediatric assent. We defend this claim by focusing on the importance of what, in a previous article in this journal, we have called "capacity for preferences"[14] and which we invoke here to defend pediatric assent. The notion of capacity for preferences underscores that the moral value of a patient's preferences is not reducible to considerations of either autonomy or best interests. Instead, their preferences have independent moral weight in medical decision-making. Such an understanding of the moral value of patient preferences strengthens the case for pediatric assent and supports revisions to three aspects of the AAP's guidance: whether to solicit assent from child patients when a particular treatment outcome is inevitable, how providers should respond when treating child patients over their objections, and more generally, how to conceive of the moral terrain of pediatric medicine.

Before we proceed, it may be helpful to clarify that we do not address questions about the legal authority of children's assent or dissent, the best way to balance children's preferences against parental permission (especially in situations of conflict), the relative weight of parental permission and physicians' judgments in situations of conflict with child patients, or developmental questions about when children can engage in different degrees of pediatric assent. These are important questions, but to sufficiently address them, we first must possess the best possible account of the moral value of pediatric assent. This article contributes to the development of such an account.

Children's Capacity for Preferences

Many adult patients who fail to meet the criteria for decision-making capacity nonetheless retain the ability to reliably express wishes or desires.[15] In our view, considerations of liberty and respect for persons provide defeasible reasons for treating these patients in accordance with their preferences. These considerations provide an *additional* moral reason to involve such patients in decision-making about their care—a reason that does not reduce to either best interests[16] or respect for (surrogate) autonomy,[17] as some have suggested.[18]

Children who lack decision-making capacity can also have wishes or desires about their treatment. Indeed, there is evidence that even infants can sometimes use nonverbal means to express preferences about their care—for example, preferences regarding feeding schedules or lighting levels.[19] Considerations of liberty and respect for persons provide defeasible reasons for granting the preferences of children of all ages, in much the same way as they tell in favor of granting the preferences of adult patients who lack decision-making capacity. (This means that children's preferences always have some moral weight, but not that they should always be authoritative or that they matter as much as the preferences of decisionally incapacitated adult patients.)

A person's claim to liberty is a reason to allow them to make decisions about their own life and, in particular, decisions about what happens to their body. This is true irrespective of a person's capacity for decision-making, though a person's inability to make reasoned judgments can make a person's liberty claims more easily defeated by other considerations (such as their best interests). So, for example, even a person with advanced dementia retains a liberty right to bodily integrity, although that right may be defeated in cases when doing so will prevent significant pain or suffering. This does not mean that such a person lacks liberty rights, but only that such rights can be defeated by weightier countervailing considerations.

Children have a claim on liberty (we leave aside questions about whether to think about this claim as a right), although adults are ethically permitted, and often obligated, to violate children's liberty to protect them from harm or to otherwise promote their important interests. For example, parents may restrain their children's bodies when they attempt to run into the street; indeed, parents have an obligation to do so. But this means only that a child's claim on liberty may be defeated by more pressing considerations, not that children lack a moral claim to liberty. It also means that it would be morally wrong to restrict a child's liberty without a good reason for doing so, since there is always a moral loss involved in using coercion against a child. For example, we take for granted that it is wrong for a parent to restrain a child just because the child's struggles amuse the parent, even though it is permissible to restrain children when there are good reasons to do so—and even though parents' interests can sometimes be good reasons for treating children in particular ways.[20]

The idea of respect for persons centers around the notion that there is something inherent about persons that creates limitations on what others may do to them. We take for granted that even people who lack decision-making capacity can be persons. However, as we have elaborated elsewhere,[21] even if the possession of full autonomy were necessary for moral personhood—an extreme Kantian view that we suspect few people accept but that is implicit in some clinical ethics literature—beings who are less than fully autonomous may be owed a kind of respect that accords with the degree to which their forms of rationality and cognition approach Kantian autonomy. Adult patients who lack decision-making capacity are still persons. Showing respect for such patients requires granting some authority to their preferences.

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Children also are persons. Indeed, the core AAP documents on pediatric assent identify "respect for persons" as a reason to involve even young children in decision-making about their care. However, the AAP could better explain why children are moral persons deserving of respect, since Kantian autonomy (which these documents invoke) cannot ground the moral personhood of most children. We return to this point later, but for now, suffice it to say that respecting children as persons entails that their expressions of preferences can constrain what we may do to them even when they lack decision-making capacity. In turn, respecting child patients requires that we take seriously their claim to participation in decision-making about their care even when they lack autonomy. That is, while we accept that the weight of a patient's preferences should be proportional to the degree to which they approach the potential for autonomous reasoning, preferences always have non-zero moral weight.[22] The mere fact that a patient has a preference demonstrates that they possess a kind of personhood that deserves respect.

It may help to say something briefly about what counts as a preference in pediatrics. We identify a preference as an at least somewhat stable communicated desire for one intervention or outcome over another.[23] A preference need not be an ideal option; it need only be favored over another live option. In fact, patients often face choices between options that exclude their most preferred outcomes; most children, for example, would prefer no treatment at all. When the ideal option is taken off the table, children may still prefer one treatment option over another (for example, oral medication over intramuscular injection). Additionally, the stability of a preference matters. More stable preferences have greater moral worth than less stable preferences, and a child patient who alternates constantly between contrary treatment preferences may not even be meaningfully said to possess a preference at all.

We derive a more robust grounding for the moral value of assent from the notion that children have claims to liberty and exhibit forms of personhood that require respect. Pediatric assent cannot be grounded in either autonomy (since many children are not autonomous) or best interests (since children may prefer options contrary to their best interests). We agree, therefore, with Amanda Sibley and colleagues, who have argued that the best defense of pediatric assent, in the context of children's participation in research, is that it demonstrates respect for the "moral worth" that even nonautonomous children possess.[24] Our account of capacity for preferences fleshes out what this entails.

Deficient Accounts of the Value of Pediatric Assent

The AAP identifies both instrumental and noninstrumental reasons for valuing pediatric assent. We think that some of these reasons will often count in favor of pediatric assent, but we worry that they are less powerful or stable than they may seem to be. Capacity for preferences provides a stronger and more stable ethical foundation for pediatric assent.

Instrumental reasons. There is a set of instrumental reasons for valuing pediatric assent in the context of treatment.[25] First, pediatric assent may promote compliance: involving children in health care decision-making may encourage them to "buy into" the results of that process.[26] This claim is bolstered by evidence that involving patients in decision-making encourages compliance.[27] Second, pediatric assent may lead to better overall health outcomes not only because of compliance but also because children may have meaningful verbal or nonverbal contributions to make to deliberations about their care.[28] Third, pediatric assent may encourage the development of the child patient's autonomy.[29] It may foster future autonomous interactions with health care providers by teaching children how to engage in authoritative health care decision-making.[30] Indeed, all these reasons may also count in favor of involving *parents* in decision-making about medical interventions for their children, as we have argued elsewhere.[31]

Ultimately, however, these reasons for valuing pediatric assent are contingent, since they rely on empirical claims about how pediatric assent can promote other goods. These reasons will not tell in favor of pediatric assent when involving children in decision-making would not encourage compliance, disclose relevant information, or foster future autonomy. Suppose, for example, that a patient is a noncompliant child who has no relevant information to disclose and who will never develop autonomous decision-making capacity (for example, because of an intellectual disability). We think, in accordance with the spirit of the AAP guidance on pediatric assent, that there are moral reasons to involve such a patient in decision-making about their care. However, the instrumental reasons described above cannot support pediatric assent in such a case. The contingency of the best interests defense of pediatric assent is worrisome not only because of its instability but also because, as Sibley et al. observe, "it is precisely a concern for the child's best interests, both short-term and long-term, that motivates us to deny children any degree of self-determination."[32] So, even though best interests considerations may often count in favor of pediatric assent, they can also present a direct challenge to involving children in meaningful participation in decision-making about their care.

Noninstrumental reasons. The AAP statements also identify reasons to value pediatric assent that may be noninstrumental. These include that pediatric assent cultivates trusting relationships with clinicians,[33] promotes a patient's understanding of their diagnosis and treatment,[34] demonstrates respect for a child's developing autonomy,[35] and (more generally) empowers child patients.[36] It is possible that some of these reasons collapse into the sorts of instrumental reasons we discussed above. For example, perhaps cultivating trust and promoting understanding matter only because they improve compliance and promote better outcomes. We might similarly attempt to reduce the concern that physicians show respect for a child's developing autonomy to a forward-looking commitment to help a child eventually become an autonomous adult decision maker. If a child is a potentially future autonomous patient, then acts that promote the child's future autonomy may promote the child's interests.

However, perhaps the AAP also has in mind that these considerations provide noninstrumental reasons to value children's participation in health care decision-making. The AAP intimates as much when it bemoans the fact that children's relative powerlessness "diminishes the[ir] moral status"[37] or when it notes that involving children in decision-making about their health care "demonstrates respect for the patient's emerging autonomy."[38] The idea that providers have a responsibility to respect children's "evolving autonomy" is common in the literature on pediatric assent.[39]

We agree that there are noninstrumental moral reasons to value children's participation in decision-making about their health care, as we discussed in the previous section. However, autonomy cannot ground these noninstrumental reasons to value pediatric assent. The 2016 AAP guidelines run into trouble on this point, grounding the moral value of respecting child patients in Kantian autonomy in a way that ultimately weakens the AAP's case for pediatric assent. Aviva Katz and Sally Webb argue that

> [Kant's categorical] imperative notes that we are obliged to act out of fundamental *respect for other persons by virtue of their personal autonomy*. This imperative forms

> the moral basis to respect others and ourselves as moral equals and provides moral support for the concept of informed consent. Although many, if not most, patients in pediatric practice lack the agency required to be truly autonomous agents, this framework remains important in providing the background for continued respect of their moral potential.[40]

This sort of argument is familiar in bioethics: someone is a moral person by virtue of their possession of autonomy, and we respect persons when we treat beings who possess autonomy in ways they can agree to be treated (as by granting authority to their preferences about their health care).[41] However, it remains unclear how Kantian autonomy could provide a basis for respecting nonautonomous agents, even if those agents may possess autonomy at a future time.[42] Sabrina Derrington and Erin Paquette have recently observed that this sleight of hand is common in pediatric ethics, according to which providers are inveighed to respect child patients as persons, in the absence of "other aspects of the typical language around respect for persons, such as *autonomy* or *self-determination*," but, somewhat paradoxically, in a context in which those Kantian ideals are presumed to be the basis of respect for persons.[43] As Sibley et al. put the point, "If we think that the child's refusal should be respected, by definition, it cannot be because we ought to respect the child's autonomy."[44]

We are similarly skeptical about the claim that because children will typically become autonomous, they ought to be respected as persons. If we treated a being's likely future status as indicative of its current personhood status, this would have an absurdly explosive or eliminative impact on the membership of the class of persons. For example, zygotes have a potential future as autonomous agents. Is that sufficient reason to treat them as persons? Or consider that autonomous agents will become nonautonomous corpses. Does this fact count against autonomous agents' claims to personhood? If not, why would we think that a being's future state could count only in favor of their personhood, rather than against it?

Without answers to these vexing questions about personal identity and the intertemporal grounding of moral status, we think it is critical to endorse accounts of respect for persons that do not ground personhood on claims about a being's (potential) future autonomy. Others who have confronted the unsuitability of autonomy for grounding the authority of children's health care preferences have responded by arguing for a diminishment of children's authority relative to parental authority[45] or have endorsed merely contingent consequentialist justifications for children's decision-making authority.[46] Turning to capacity for preferences, however, helps to deliver on the commitment the AAP has made to the moral value of children's participation in their health care. This is because the capacity for preferences approach does not ground children's preferences in either the inapplicable value of autonomy or in the unstable consequences of pediatric assent for the promotion of children's best interests.

The moral value of a patient's preferences is not reducible to considerations of either autonomy or best interests. Instead, these preferences have independent moral weight in medical decision-making.

Capacity for Preferences and Pediatric Assent

We have argued that the assent and dissent of pediatric patients always have moral weight, as a consequence of their capacity for preferences. However, countervailing reasons, grounded in the best interests of the patient, can be weightier than the reasons in favor of granting authority to patients' preferences. When best interest considerations have greater relative weight than the reasons for granting a child patient's preferences, health care teams should promote the child's best interests rather than accede to the child's preferences. While preferences always matter morally, there are many cases in which they should not be authoritative.

The AAP has built its admirable attempts to promote children's participation in health care decision-making on unstable foundations. We have argued that capacity for preferences provides a more stable foundation for—and a stronger defense of—pediatric assent, and we recommend that the AAP reverse the guidance that children's preferences should not be solicited when particular treatments are foregone conclusions. Furthermore, we suggest that the AAP identify a more limited scope for treatments that should be considered foregone conclusions. Revisions to both these aspects of AAP guidance would demonstrate greater respect for child patients as persons and would reflect the stronger account of pediatric assent that capacity for preferences grounds.

The three AAP documents that address pediatric assent hold that children's assent should not be solicited if a particular treatment option is inevitable:

> [N]o one should solicit a patient's views without intending to weigh them seriously. In situations in which the patient will have to receive medical care despite his or her objection, the patient should

> be told that fact and should not be deceived.[47]
>
> [O]ne should not solicit a child's assent if the treatment or intervention is required to satisfy goals of care agreed on by the physician and parent or surrogate.[48]
>
> [A]ssent should only be solicited if some element of refusal will be respected.[49]

The AAP counsels that children should not be asked whether they assent to treatment in cases in which they may not receive the treatment options they prefer. Instead, the AAP suggests that a child patient's preferences be solicited only when those preferences will be authoritative. This guidance is widely echoed by advocates of pediatric assent, in both clinical and research contexts.[50] Such guidance presents both practical and ethical problems.

The AAP documents make it clear that carrying out the other aspects of the pediatric assent process is still necessary when providers believe that soliciting a child's preferences about a treatment option is inappropriate.[51] As listed above, these include cultivating the child's awareness of his or her condition, informing the child about the treatments, and assessing the child's understanding of the condition and treatments. Practically speaking, however, it is not clear how these three activities could be reliably divested from solicitations of children's preferences about their health care. For example, a question that aims to assess a child's understanding of a potential treatment option ("Can you tell me what about this surgery worries you?") may easily, if unintentionally, solicit a child's preferences about that treatment. So, one reason to revise the AAP guidance not to solicit children's preferences when particular treatments are inevitable is that separating solicitations of preferences from other aspects of the pediatric assent process may be impossible.

A more serious reason to revise the AAP guidance is that it wrongly assumes that one cannot "weigh seriously" a child's preferences when a particular treatment is a foregone conclusion and, therefore, that soliciting assent in such circumstances risks deceiving a child.[52] We agree that it would be deceptive and disrespectful to intimate that a child will get the treatment option he or she prefers only to impose the treatment option that was rejected. But there are other ways to solicit a child's treatment preferences. For example, imagine a physician is caring for an eight-year-old child diagnosed with medulloblastoma. The physician says, "We need to do a surgery to remove your tumor, and this kind of tumor can spread to other parts of your body, so we need to get it out of there soon. It is so important for your health that we *have* to do it. But I'd still like to know how *you* feel about having surgery." This sort of solicitation of a child's preferences shows respect for the child as a person—a being whose preferences matter enough to be heard—even in cases in which those preferences will not be decisive. The AAP documents insist that a child's preferences be solicited only when they will be decisive, but preferences do not have to be decisive to be treated seriously or to be given substantial weight. Indeed, it shows greater respect for a patient to acknowledge that they are being treated over their objection than to actively avoid acknowledging instances of treatment over objection. A practice of soliciting assent even when treatment options are foregone conclusions acknowledges objections that may otherwise have been suppressed.

The moral value of preferences also provides a reason to revise the AAP's ambiguous description of the contexts in which it is appropriate to conceive of particular treatments as inevitable. The 2016 AAP statements clarify that one circumstance in which children will have to receive a treatment is when a failure to provide that treatment would cause "significant risk of serious harm," which the AAP has historically operationalized to mean death, lasting impairment, or severe pain.[53] We agree that this is a context in which it is reasonable to treat a child over his or her dissent. As we note above, however, preferences should still be solicited in such circumstances, in respectful and nondeceptive ways. However, it is not clear that the AAP means to limit instances of "required" care to cases in which it would harm children not to pursue the proposed interventions. For example, the 2016 AAP statement says that treatments can be thought of as inevitable when they are "required to satisfy goals of care agreed on by the physician and parent or surrogate."[54] However, if those goals of care are sufficiently expansive, for example, to include the maximal promotion of the child's medical best interests (as understood by parents and physicians), then all treatments on which parents or physicians have preferences would be required treatments, and the AAP's guidance would require never soliciting a child's assent.

Consider a case in which a one-time intramuscular injection and a two-week oral regimen were equally effective. The physician prefers the intramuscular injection only because it ensures compliance, but the child prefers the oral medication because she is afraid of needles. We think the child's preference could be decisive in this kind of case if we suppose that the child's potential noncompliance with oral medication did not present a "significant risk of serious harm." Yet if the injection was "required to satisfy goals of care agreed on by the physician and parent or surrogate"—such as the maximal promotion of the child's medical interests—the AAP guidance says it would be inappropriate to solicit the child's preferences (or to grant them any authority). Therefore, the AAP's expansive conception of "inevitable" care is, perhaps unintentionally, a back door to the systematic exclusion of children from participation in their health care decision-making.

Bartholome and Apologizing to Children

We are not the first to observe that the AAP's conception of pediatric assent may provide too little protection for children's participation in their health care decision-making. William Bartholome was an early advocate of pediatric assent,[55] and he wrote the first draft of the 1995 AAP statement on this topic. Bartholome was dismayed at how the authors of the final draft weakened his claims about a child's moral right to participate in decision-making about their care. In a fiery letter to the editor of *Pediatrics*, Bartholome argued that children's preferences should always be consulted, even when physicians believe a particular intervention or treatment is a forgone conclusion; to do otherwise was to make "a mockery of the whole idea of assent."[56]

Bartholome claimed that physicians may be able to convince dissenting child patients to change their minds. But even if physicians could not persuade dissenters, Bartholome thought it was still important to solicit children's preferences, so that physicians could own up to the ultimately justified moral transgression of treating children over objections. "[T]he pediatrician should," he argued, "acknowledge to the child that the child had likely experienced this 'forced treatment' as disrespectful of him/her as a developing person, i.e., . . . the pediatrician should apologize to the child for the fact that the child was 'forced' to undergo the intervention."[57] If physicians solicit a child's assent for a particular treatment, then they will know whether they are treating the child against her preferences. And according to Bartholome, a physician should offer an apology in such contexts, to show respect for the child patient who will have interventions performed on her body over her objections. Our account of capacity for preferences helps explain why Bartholome was right.

There are often morally regrettable aspects of actions that are, all things considered, the morally best actions available to us. One way to understand such phenomena is as a consequence of moral pluralism—the idea that there is more than one fundamental value, such that at least two values cannot be reduced to quantities of a common supervalue.[58] If value pluralism were false, and if all values could be reduced to quantities of a single supervalue, then it would not be rational to regret outcomes in which one achieved more, rather than less, of the only thing that mattered. But we do sometimes feel regret even when we believe ourselves to have chosen the morally best option. Value pluralism can make sense of this regret, on the grounds that even acts that are, all things considered, morally best can still involve an uncompensated moral loss.[59] We argue that treating children against their preferences in order to protect them from serious harm is the right thing to do and yet always involves an uncompensated moral loss. The respectful way to respond to a moral loss one has caused is to acknowledge the loss and to express regret for it, even when one has acted in what is the all-things-considered morally best way. An apology of the sort that Bartholome defends can accomplish this purpose.

Child patients' preferences are constantly at risk of being subjugated. Pediatric providers need support that does not neglect or obfuscate the moral nuances of their work.

On a personal note, both of us have witnessed our children's pediatric providers apologize when they have treated our children over their objections. One of us remembers vividly the experience of restraining his four-year-old so that she could receive her scheduled vaccines. The nurse said, "I'm sorry, honey, but I'm going to give you these shots because they are really good for you." We don't know the extent to which this nurse was providing a well-thought-out response to the moral dimensions of this clinical encounter, but we like to think that the nurse was at least intuitively responding to the notion that restraint and coercive treatment were morally regrettable, even though coercive treatment was justified by best interest considerations (the shots were "really good" for the child). Perhaps Bartholome's insight reflects an intuition that is widely shared among pediatric providers but that has not been well explicated in either the pediatric ethics literature or AAP guidance.

Pediatrics and Ethical Complexity

Pediatric decision-making is more ethically complex than is implicitly represented in AAP's guidance. Child patients commonly dissent from, or do not assent to, interventions that are morally justified for health care teams to impose coercively. And, as we have argued, such coercion is morally regrettable, even when it is ultimately justified by weightier considerations. Therefore, pediatric practice may frequently involve clinicians in ethical violations that are unavoidable but ultimately justified. The vulnerability of pediatrics to ethical violations can be amplified when pediatricians build therapeutic alliances with children (for example, to discontinue a burdensome therapy) that are then undermined by parental decisions (for example, to continue treatment).

It can be difficult for human beings to acknowledge that good outcomes sometimes have regrettable aspects. The human disposition toward an affect heuristic[60] suggests that we tend to think the outcomes we desire have few or no downsides.[61] Perhaps this common psychological tendency helps explain why the AAP documents on pediatric assent implicitly embrace the contradictory conclusion that child patients' preferences should have *no* moral weight (and ought not to be solicited) if other considerations are decisive (when the best interests standard makes the treatment decision a foregone conclusion). We suggest that the AAP revise its guidance surrounding pediatric assent to better defend the moral value of children's participation in their health care decision-making and, more generally, to provide a richer characterization of the ethically challenging work of pediatrics.

It can be taxing for health care teams to coercively impose treatments on *adult* patients who lack decision-making capacity. It takes a kind of moral bravery to do this work because treating patients over their objections always involves moral violations, even when coercive treatment is ultimately ethically justified.[62] Unlike with adults, where treatment over objection is relatively rare, pediatrics systematically involves these kinds of cases, since children, and especially very young children, refuse many interventions that pediatric providers are ethically justified or even ethically obligated to impose. While the preferences of normally or formerly competent adult patients are usually overwhelmed only in the context of acute care and end-of-life decision-making, children's preferences are constantly at risk of being subjugated, including at well visits (for immunizations, for instance), in routine surgical interventions (such as a hernia repair), and in emergencies. It is important to acknowledge the complex moral demands of pediatrics and to give pediatric providers forms of support that do not neglect or obfuscate the moral nuances of their work.

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