Non-COVID-19 Patients Left out in the Cold –Inevitable Outcome of Pandemic Ethics?

Dear editor in chief of Voices in Bioethics,

Please receive this submission for your consideration as an Op-Ed. This piece has not been published elsewhere. Nor is there any conflict of interest. I am a MS in Bioethics program student (cc4419).

Thank-you in advance for your time.

Kind Regards,

camillecastelyn@gmail.com; +27795065117

Non-COVID-19 Patients Left out in the Cold – Inevitable Outcome of Pandemic Ethics?

1. Introduction

Countries across the globe including the United States (US) and South Africa have recently reported a surge of non-COVID-19 related deaths.[1] As there is limited accurate and reliable data of this new problem emerging during the COVID-19 pandemic,[2] the full extent of the problem is unknown. The lack of data makes it difficult to understand the gravity of the situation and to address it. Medical professionals are asking why these non-COVID related cases did not present at hospitals. Aside from each country's unique demographics influencing the ability to treat pre-existing chronic diseases alongside COVID-19, resource allocation may lie at the heart of the problem.[3]

The World Health Organization's[4] declaration that COVID-19 was a pandemic on March 12 2020 placed the fight against COVID-19 front and center in most countries across the world. Italy was one of the first countries to be hit hardest, as localized lockdowns expanded to a countrywide lockdown in a desperate attempt to stop the outbreak. In the US, the first case was confirmed on January 21 2020.[5] Presidential actions lagged in decisiveness[6] leading to disproportionate loss of life[7] and diminishing hopes of containing the outbreak. In South Africa, swift action included a lockdown long before community spread was confirmed, [8] which slowed the initial spread of the virus. This swift response may be attributed to the fresh memories of Malaria and HIV, which remain a threat. A proactive lockdown like this does come at a price. Buying time for Emergency Departments (EDs) and medical professionals to prepare[9] meant slowing the economy to a halt.

In different countries across the world, healthcare was accessible to varying degrees prior to the pandemic. In South Africa, the healthcare system is severely strained[10] in comparison to nations like the US. A non-COVID-19 patient's ability to access healthcare during this time has been limited. For example, routine child vaccinations have been disrupted,[11] critical delivery of anti-retroviral drugs for HIV treatment has been disrupted, non-elective surgeries have been suspended, cancer patients have been receiving limited treatment,[12] and mothers have had limited labor and delivery care.[13] While these disruptions occur in other nations as well, countries

with more robust healthcare systems may be able to bear the brunt of this burden more successfully than nations like South Africa. These disruptions are not trivial and add pressure on healthcare systems in both the short and long run.

2. Status quo of Resource Allocation Re-evaluated

The status quo of resource allocation both within and outside a clinical setting in this pandemic prioritizes COVID-19 tacitly and overtly. If two patients of equal need and prognosis arrive at an ED, it is more likely that the patient with COVID-19 symptoms will be treated first, or at the very least be transferred to a separate room or hospital section. Furthermore, non-COVID-19 patients have avoided EDs due to fear of contracting COVID-19.[14] Up until now, most people would argue that this is a necessary sacrifice to mitigate the impact of COVID-19. However, increased deaths of non-COVID-19 patients have brought a re-evaluation of the current status quo. This re-evaluation is further complicated by a global shortage of medical staff and medical equipment (including PPE and ventilators).

Many ethical frameworks and guidelines have been issued to help navigate these uncharted waters of pandemic ethics in the 21st century.[15] All of these frameworks inevitably have underlying value judgements and prevalent ethical principles that guide resource allocation. These principles can be divided into four categories – maximizing total benefits, treating people equally, promoting and rewarding social usefulness, and favoring those that are worst off.[16] Prioritizing COVID-19 patients in a pandemic maximizes total benefits for all in a pandemic situation.[17] However, this approach has also led to people dying at home from conditions that could have been effectively treated in a hospital setting.

Maximizing total benefits is a utilitarian approach. However, the tension between providing the best possible care and respecting an individual's autonomy, while also saving the greatest number of lives, has once again been re-evaluated.[18] Often, pandemic ethics single out one principle, such as utilitarianism; however, this has proven to be detrimental. Consequently, there is a shift toward utilizing multi-principle allocation systems.

In the past, a multi-principle allocation system as described by Persad et al., has ensured distributive justice when applied to scarce medical interventions on allocation of organs and vaccines.[19] In these instances, choosing only one of the principles, such as youngest first or favoring those with the best prognosis or those who are worst-off, may favor a certain group of people at the cost of another. This is inefficient if we consider the concept of distributive justice as first described by John Rawls.[20] Rawls described the veil of ignorance, where in order for one to gauge whether decisions are adequate, one must conduct a thought experiment from behind the veil of ignorance. For example, if you choose to prioritize those who are youngest first, without knowing whether the person standing behind the veil is young or old, your decision should be fair to whoever is behind the veil.

Amid COVID-19, a multi-principle approach would address the moral complexities of these perplexing decisions better than a one principled approach such as maximizing the most lives. It would take into account numerous principles even though they may seem to be in tension with one another. This would include socio-economic factors as well, while aiming to treat people equitably and also taking into account those who are worst off.

Opposing critics might argue that saving the most lives, with specific reference to triage protocols, is the only way to enable healthcare workers to make fast and efficient decisions in hospital settings. These approaches do have their rightful place in resource allocation. However, this article makes a plea toward the complexities of pandemic ethics that should be factored in.

3. Drawing on Past Experiences

South Africa and other African countries have experienced other severe infectious disease outbreaks such as AIDS and Ebola, an extremely valuable occurrence that should be drawn upon.[21] For example, allocating scarce resources amid outbreaks of Ebola trained medical professionals to act efficiently and intuitively. Ebola and HIV also sparked innovation and identification of creative uses for available resources.

South Africa has been grappling with the HIV crisis for 20 years. It has vast experience in tracking and studying viruses. Furthermore, a lot of specialized research has been done for the past 15 years to study people's

immune responses to HIV.[22] Technologies are being repurposed to investigate what immune responses can be expected from patients infected with SARS-CoV-2.[23] South Africa is also well suited for vaccine trials as it has been a major contributor of sites for internationally funded clinical trials. Consequently, a landmark COVID-19 treatment trial has already been lined up. [24]

In West Africa, surveillance techniques that were developed for the 2014-2015 Ebola outbreak, which infected 28,000 people and killed 11,000 people in Guinea, Liberia, and Sierra Leone, are now being deployed in the fight against COVID-19.[25] [26]

Across the continent, lessons learned include the critical importance of adequate respect for culture, appropriate community engagement and education, vigilance in reports of symptoms, and leveraging past research and laboratory capacities for testing and clinical vaccine trials.

4. Limitation to This Approach and Proposed Interventions

Already strained healthcare systems may risk great losses in regarding the overall health of the population if the limited care that has been offered before this pandemic is jeopardized. For example, the disruption of anti-retroviral treatments has serious consequences for the patients due to the high mutation rate of HIV, which makes the treatment plan time sensitive. Other examples include many homeless people who are on methadone treatment, who at the moment are still receiving mobile delivery of their treatments. If there were complications in delivering these medications, we could see many people with extreme symptoms of withdrawal and great setbacks for people wanting to 'come clean.' Cancer patients also report that they find themselves having to decide whether they are willing to risk contracting COVID-19 when going in for routine treatments or skipping treatments now and risking cancer later.

Interventions, including telemedicine, should be prioritized. Although there may also be unique challenges of exposure to healthcare professionals upon home visits, these risks must be evaluated and mitigated to ensure continuation of care. Some hospitals in the US are currently evaluating the impact and effectiveness of current telemedicine approaches. Midwives and other healthcare workers should also be trained adequately and

dispersed to deliver care at home. Furthermore, this challenging time may also serve as an impetus for all stakeholders to prioritize improving healthcare delivery for all, albeit through seemingly unrelated victories, such as adequately communicating and educating local communities on basic healthcare or delivering basic sanitary services like running water and improved infrastructure.

5. Conclusion

The very nature of pandemic ethics provides unforeseen challenges such as the one that has been described here. A multi-principle approach, which also draws on past experiences, will empower all global stakeholders (governments, leaders, patients and medical professionals alike) to make choices that enable equitable resource allocation.

---

[1] Krumholz, Harlan. 2020. "Where Have All the Heart Attacks Gone?," April 6, 2020. https://www.nytimes.com/2020/04/06/well/live/coronavirus-doctors-hospitals-emergency-care-heart-attack stroke.html?algo=identity&fellback=false&imp_id=450663239&imp_id=67343380&action=click&module=Science%20%20Technology&pgtype=Homepage. Walsh, James D. 2020. "The Mystery of 'Excess Fatality.'" *Intelligencer*, April. https://nymag.com/intelligencer/2020/04/coronavirus-is-only-part-of-the-excess-fatality-mystery.html.

[2] Gillum, Jack, Lisa Song, and Jeff Kao. 2020. "There's Been a Spike in People Dying at Home in Several Cities. That Suggests Coronavirus Deaths Are Higher Than Reported." *ProPublica*, April 14, 2020. https://www.propublica.org/article/theres-been-a-spike-in-people-dying-at-home-in-several-cities-that-suggests-coronavirus-deaths-are-higher-than-reported.

[3] Bettina Taylor, Jeannette Parkes, and Johannes J Fagan, "How Should Health Resource Allocation Be Applied during the COVID-19 Pandemic in South Africa?," *South African Medical Journal (Online)*, May 20, 2020, https://doi.org/. https://doi.org/10.7196/SAMJ.2020. v110i7.14916.

[4] World Health Organization. 2020. "Rolling Updates on Coronavirus Disease (COVID-19)," April 28, 2020. https://www.who.int/emergencies/diseases/novel-coronavirus-2019/events-as-they-happen.

[5] Centers for Disease Control and Prevention. 2020. "Coronavirus Disease 2019: Cas in US," February 5, 2020. https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html.

[6] Larry Buchanan, Rebecca KK Lai, and Allison McCann, "U.S. Lags in Coronavirus Testing After Slow Response to Outbreak," *The New York Times (Online)*, March 17, 2020, https://www.nytimes.com/interactive/2020/03/17/us/coronavirus-testing-data.html.

[7] John Eligon et al., "Black Americans Face Alarming Rates of Coronavirus Infection in Some States," *The New York Times (Online)*, April 14, 2020, https://www.nytimes.com/2020/04/07/us/coronavirus-race.html.

[8] Cyril Ramaphosa, "Message by President Cyril Ramaphosa on COVID-19 Pandemic 30 March," March 30, 2020, http://www.thepresidency.gov.za/speeches/message-president-cyril-ramaphosa-covid-19-pandemic; Cyril Ramaphosa, "Message by President Cyril Ramaphosa on COVID-19 Pandemic 9 April," April 9, 2020, http://www.thepresidency.gov.za/speeches/message-president-cyril-ramaphosa-covid-19-pandemic-0.

[9] Road accident fatalities over the Easter weekend decreased from 128 people in 2019 to 28 in 2020 (Saleka 2020). Emergency Departments (ED) were also eerily quiet - decreasing from 34 000 cases per week to 12 000 cases per week. BBC. 2020. "South Africa Coronavirus Lockdown: Is the Alcohol Ban Working?," April 22, 2020. Saleka, Ntwaagae. 2020. "28 Died in Accidents during the Easter Weekend, While 719 Arrested for Traffic Violations." *News24*, April 17, 2020. https://www.news24.com/SouthAfrica/News/28-died-in-accidents-during-the-easter-weekend-while-719-arrested-for-traffic-violations-20200417.

[10] N Aikman, "The Crisis within the South African Healthcare System: A Multifactorial Disorder," *South African Journal of Bioethics and Law* 12, no. 2 (n.d.): 52–56.

[11] UNICEF. 2020. "COVID-19 Putting Routine Childhood Immunization in Danger: UN Health Agency." *United Nations News*, April. https://news.un.org/en/story/2020/04/1062712.

[12] Vanderpuye, Verna, Moawia Mohammed, Ali Elhassan, and Hannah Simmonds. 2020. "Preparedness for COVID-19 in the Oncology Community in Africa," April. https://doi.org/10.1016/ S1470-2045(20)30220-5.

[13] Menconi, Michael. 2020. "NY Hospitals Issue Problematic Ban on Birthing Support Persons from Labor & Delivery Units." *Voices in Bioethics*, March. http://www.voicesinbioethics.net/voices-in-bioethics/2020/3/28/ny-hospitals-issue-problematic-ban-on-birthing-support-persons-from-labor-amp-delivery-units.

[14] Krumholz, Harlan. 2020. "Where Have All the Heart Attacks Gone?," April 6, 2020. https://www.nytimes.com/2020/04/06/well/live/coronavirus-doctors-hospitals-emergency-care-heart-attack stroke.html?algo=identity&fellback=false&imp_id=450663239&imp_id=67343380&action=click&module=Science%20%20Technology&pgtype=Homepage.

[15] The South African Medical Association. 2020. "SARS-CoV-2 (COVID-19) Guidance for Managing Ethical Issues (Living Document)." The South African Medical Association. Wisner, Benjamin, John Adams, and World Health Organization, eds. 2002. "Environmental Health in Emergencies and Disasters: A Practical Guide." World Health Organization. https://apps.who.int/iris/bitstream/handle/10665/42561/9241545410_eng.pdf?sequence=1. Nuffield Council on Bioethics. 2020. "Rapid Policy Briefing: Ethical Considerations in Responding to the COVID-19 Pandemic." Rapid Policy. London: Nuffield Council on Bioethics. https://www.nuffieldbioethics.org/assets/pdfs/Ethical-considerations-in-responding-to-the-COVID-19-pandemic.pdf. Berlinger, Nancy, Matthew Wynia, Tia Powell, Micah Hester, Aimee Milliken, Rachel Fabi, Felicia Cohn, et al. 2020. "Ethical Framework for Health Care Institutions Responding to Novel Coronavirus SARS-CoV-2 (COVID-19) Guidelines for Institutional Ethics Services Responding to COVID-19 Managing Uncertainty, Safeguarding Communities, Guiding Practice." The Hastings Center. thehastingscenter.org/ethicalframeworkcovid19.

[16] Persad, G, Alan Wertheimer, and Ezekiel J Emanuel. 2009. "Principles for Allocation of Scarce Medical Interventions." *Lancet* 373: 423–31.

[17] Ibid.

[18] Dale, Samuel. 2020. "Utilitarianism in Crisis." *Voices in Bioethics*, August. http://www.voicesinbioethics.net/voices-in-bioethics/2020/5/8/utilitarianism-in-crisis.

[19] G Persad, Alan Wertheimer, and Ezekiel J Emanuel, "Principles for Allocation of Scarce Medical Interventions," *Lancet* 373 (2009): 423–31.

[20] John Rawls, *A Theory of Justice* (Oxford: Oxford University Press, 1999).

[21] MM Kavanagh et al., "Access to Lifesaving Medical Resources for African Countries: COVID-19 Testing and Response, Ethics, and Politics," *The Lancet*, July 5, 2020, https://doi.org/10.1016/ S0140-6736(20)31093-X.

[22] Sarah Wild, "How HIV Expertise Is Helping South Africa Tackle Coronavirus," *The World Economic Forum*, September 4, 2020, https://www.weforum.org/agenda/2020/04/south-africa-hiv-coronavirus-covid19-pandemic-health-virus.

[23] Wild.

[24] Wild.

[25] 29/05/2020 20:08:00

[26] Medecins sans frontiers, "Crisis Update - May 2020," *Medecins sans Frontiers*, May 18, 2020, https://www.msf.org/drc-ebola-outbreak-crisis-update.