



# THE SOUTH AFRICAN MEDICAL ASSOCIATION

## SARS-CoV-2 (COVID-19)

### Guidance for Managing Ethical Issues

Abridged Version 1

8 April 2020

**This is a living document. As such, it will be updated as COVID-19 evolves**

Ethical dilemmas in health care are common even under normal circumstances because health care responds to human suffering. To act ethically is integral to professionalism in health care. A surge of individuals seeking health care, as well as critically ill patients with COVID-19, disrupts normal processes for supporting ethically sound patient care.

### **Obligations and duties of Doctors**

Effective outbreak response to COVID-19 depends on the valuable contribution of Doctors, some of whom may be working on a volunteer basis. Doctors, have certain moral duties during a COVID-19 outbreak, which include the following:

- A duty to self - Doctors have a duty to take care of their own health and mental well-being to maintain and improve the standard of their professional knowledge and skills in the management of COVID-19
- A duty of care to patients – A Doctor’s duty of reasonable clinical care towards patients and concern for their best interests is enhanced during the COVID-19 crisis.
- A duty to colleagues and other professionals - fellow professionals are to be treated with dignity and respect. Junior doctors should remain under the close supervision of their senior colleagues whilst simultaneously maintaining professionalism and care.
- A duty to society - During the COVID-19 crisis, Doctors, as custodians of health care, have a duty to deal responsibly with scarce health care resources and to refrain from providing services that are not needed.
- A duty to participate in public health and reporting efforts.
- A duty to provide accurate information to the public.
- A duty to advocate on behalf of their patients.
- A duty to avoid exploitation and not offer treatments for which there is no reasonable basis to believe that the potential benefits outweigh the uncertainties and risks.

### **Reciprocal obligations**

The Government, Department of Health, Private health care sector (both hospitals and funders) and society, in general, have reciprocal obligations to provide necessary support to Doctors which include:

- A safe working environment, provision of PPE and facilities and equipment appropriate to the treatment of COVID-19 infections
- Priority access to medical care for Doctors and their immediate family members who become infected through consequent exposure
- Priority access to the Covid-19 vaccine once developed – Doctors, as front-line essential workers should have priority access to the Covid-19 vaccine.

### **Informed Consent**

If the situation is life-threatening and there is no proxy available, the National Health Act (NHA) allows for treatment to be given without the consent of the patient or the proxy provided that the patient has not previously expressly, impliedly or by conduct refused such treatment. Clear records must be kept.

## **Limitations to autonomy in the context of COVID-19**

Section 4 for the Disaster Management Regulations states that no one may refuse medical investigation, testing or quarantine and isolation. This implies that informed consent is not strictly needed for the purposes of testing and treating COVID-19 for “*Persons who have been confirmed, as a clinical case or as a laboratory confirmed case as having contracted COVID -19, or who is suspected of having contracted COVID -19, or who has been in contact with a person who is a carrier of COVID -19.*”

## **Confidentiality Limitations and COVID-19**

Covid-19 is a notifiable disease, hence the law imposes a mandatory limitation to confidentiality when a patient is diagnosed with the disease. In addition, Regulation 11H(5) of the Disaster Management Regulations states that:

No person may disclose any information contained in the COVID-19 tracing database or any information obtained through this regulation unless authorized to do so and unless the disclosure is necessary for the purpose of addressing, preventing or combatting the spread of COVID-19.

## **Telehealth and COVID-19**

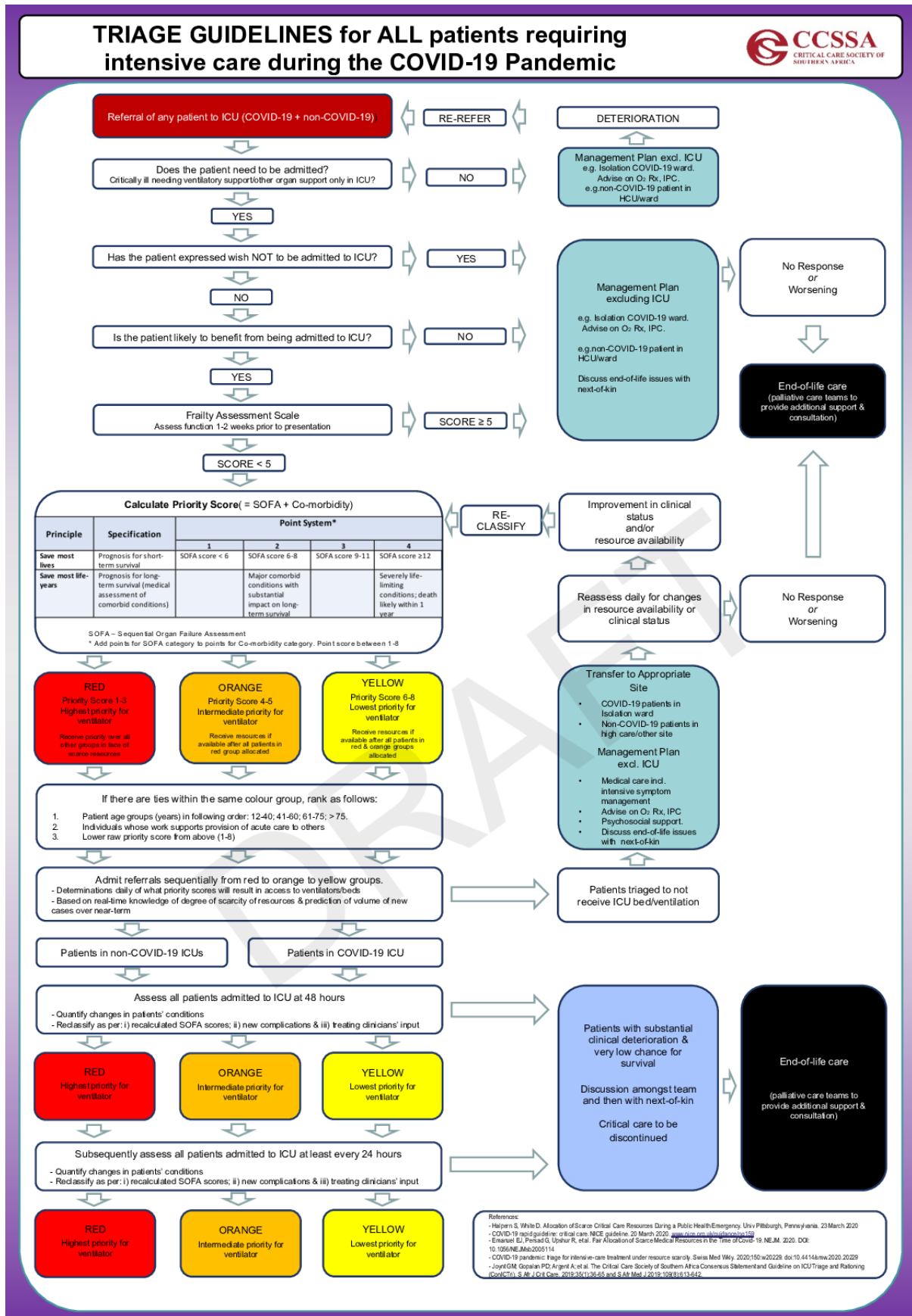
The HPCSA's amendment to its guidelines on telemedicine state that telehealth should preferably be practised in circumstances where there is an already established Doctor-patient relationship. However, where such a relationship does not exist, Doctors may still consult using telehealth, provided that such consultations are done in the best interest of patients. This therefore allows for telephonic and other forms of virtual consultations.

## **Allocation of scarce resources**

COVID-19 has the ability to quickly overwhelm the capacity of government and the healthcare system. Useful triage guidance utilising a clinical frailty scale (CFS) has been drawn up by The Critical Care Society of South Africa (CCSSA) and endorsed by SAMA. The CSF ranges from 1 to 9 as follows:

1. Very fit – those amongst the fittest for their age, and are very active and motivated.
2. Well – there is no active disease or symptoms, but not as active as in category 1.
3. Managing well – medical problems present, but well controlled. Not regularly active.
4. Vulnerable – not dependant on others for daily help, but symptoms limit activities.
5. Mildly frail – more evident slowing and need help in high order IADLS, e.g., finances, transport, etc.
6. Moderately frail – need help with all outside activities, keeping house, bathing and dressing.
7. Completely dependent for personal care, but are stable and not at high risk for dying (within 6 months)
8. Very severely frail – completely dependent, approaching the end of life and not able to recover from a minor illness.
9. Terminally ill – life expectancy of less than 6 months.
  - Patients with a CFS score  $\geq 5$  are to be offered a management plan excluding ICU.
  - The lower the score, the higher the likelihood of benefit from ICU care.

# 1. Annexure 1: CCSSA Triage Guidelines (2 April 2020)



# TRIAGE GUIDELINES for patients requiring intensive care during the COVID-19 Pandemic



## Clinical Frailty Scale\*



**1 Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.



**2 Well** – People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.



**3 Managing Well** – People whose medical problems are well controlled, but are not regularly active beyond routine walking.



**4 Vulnerable** – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being "slowed up", and/or being tired during the day.



**5 Mildly Frail** – These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.



**6 Moderately Frail** – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.



**7 Severely Frail** – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).



**8 Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.



**9 Terminally Ill** - Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

### Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common symptoms in mild dementia include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In moderate dementia, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In severe dementia, they cannot do personal care without help.

\* 1. Canadian Study on Health & Aging, Revised 2008.

2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

TABLE. Examples of comorbidities to be used for Priority Scoring

Examples of Major comorbidities (associated with significantly decreased long-term survival)	Examples of Severely Life Limiting Comorbidities (commonly associated with survival < 1 year)
<ul style="list-style-type: none"> <li>Moderate Alzheimer's disease or related dementia</li> <li>Malignancy with a &lt; 10 year expected survival</li> <li>New York Heart Association Class III heart failure</li> <li>Moderately severe chronic lung disease (e.g., COPD, IPF)</li> <li>End-stage renal disease in patients &lt; 75</li> <li>Severe multi-vessel CAD</li> <li>Cirrhosis with history of decompensation</li> <li>AIDS defining illness (or viral load &gt;10000 despite Rx)</li> </ul>	<ul style="list-style-type: none"> <li>Severe Alzheimer's disease or related dementia</li> <li>Cancer being treated with only palliative interventions (including palliative chemotherapy or radiation)</li> <li>New York Heart Association Class IV heart failure plus evidence of frailty</li> <li>Severe chronic lung disease plus evidence of frailty</li> <li>Cirrhosis with MELD score ≥20, ineligible for transplant</li> <li>End-stage renal disease in patients older than 75</li> </ul>

Table 1. Sequential [Sepsis-Related] Organ Failure Assessment Score<sup>a</sup>

System	Score				
	0	1	2	3	4
Respiration					
PaO <sub>2</sub> /FIO <sub>2</sub> , mm Hg (kPa)	≥400 (53.3)	<400 (53.3)	<300 (40)	<200 (26.7) with respiratory support	<100 (13.3) with respiratory support
Coagulation					
Platelets, ×10 <sup>3</sup> /μL	≥150	<150	<100	<50	<20
Liver					
Bilirubin, mg/dL (μmol/L)	<1.2 (20)	1.2-1.9 (20-32)	2.0-5.9 (33-101)	6.0-11.9 (102-204)	>12.0 (204)
Cardiovascular					
	MAP ≥70 mm Hg	MAP <70 mm Hg	Dopamine <5 or dobutamine (any dose) <sup>b</sup>	Dopamine 5.1-15 or epinephrine ≤0.1 or norepinephrine ≤0.1 <sup>b</sup>	Dopamine >15 or epinephrine >0.1 or norepinephrine >0.1 <sup>b</sup>
Central nervous system					
Glasgow Coma Scale score <sup>c</sup>	15	13-14	10-12	6-9	<6
Renal					
Creatinine, mg/dL (μmol/L)	<1.2 (110)	1.2-1.9 (110-170)	2.0-3.4 (171-299)	3.5-4.9 (300-440)	>5.0 (440)
Urine output, mL/d				<500	<200

Abbreviations: FIO<sub>2</sub>, fraction of inspired oxygen; MAP, mean arterial pressure; PaO<sub>2</sub>, partial pressure of oxygen.

<sup>a</sup> Adapted from Vincent et al.<sup>27</sup>

<sup>b</sup> Catecholamine doses are given as μg/kg/min for at least 1 hour.

<sup>c</sup> Glasgow Coma Scale scores range from 3-15; higher score indicates better neurological function.

Vincent JL, Moreno R, Takala J, et al. The SOFA (Sepsis-related Organ Failure Assessment) score to describe organ dysfunction/failure. On behalf of the Working Group on Sepsis-Related Problems of the European Society of Intensive Care Medicine. Intensive Care Med. 1996 Jul;22(7):707-10.

Note: In the absence of measured blood values for parameters needed for the SOFA score, it is suggested that clinical assessment of signs (such as bleeding for platelet value and jaundice for bilirubin value) by the managing doctor be performed to place the patient in the appropriate category for that parameter.