MEDICLINIC

COVID-19 INFORMATION

COVID-19 UPDATE

26 April 2021

Mediclinic Southern Africa (MCSA) COVID-19 Clinical Ethics Committee (CEC) during COVID-19

As the MCSA COVID-19 CEC appointed in 2020 we understand our role as follows:

1. The coronavirus pandemic is a public health emergency and as such resources will be limited or even overwhelmed as numbers of infected patients surge. This has already occurred in the most well-resourced, high income countries like the USA and Europe where it became necessary to triage patients for access to limited resources. Health care professionals and institutions have a duty to steward scarce resources to where they are needed most. Triage requires healthcare workers across the globe to make extremely difficult decisions as the common good supersedes individual patient autonomy.
2. These triage decisions will be made with respect to ventilators, ICU beds, high flow oxygen, hospital beds (COVID-19 and non-COVID-19), theatre lists, and general non-COVID-19 health services, amongst others.
3. Within the MCSA hospitals in Southern Africa, triage decisions will be made at different levels of care by Critical Care Triage Teams using the Critical Care Society of South Africa guidelines (CCSSA)[1], the Western Cape Critical Care Triage Tool[2] and the Tygerberg Hospital Triaging within the WC triage tool[3]. These decisions are supported by Treatment Escalation Support Teams (TEST)[4]. Most patients will be allocated to care based on such decision-making. Only once conflicts arise regarding prioritisation of patients for scarce resources and cannot be solved by the relevant TEST, will the COVID-19 Clinical Ethics Committee (CEC) be consulted.

Committee Membership

The CEC, established by MCSA in response to a perceived need for resolution of clinical ethical dilemmas during the COVID-19 pandemic, comprises a diverse multidisciplinary team of doctors, nurses, bioethicists and MCSA staff, as outlined in the Terms of Reference (Annexure A). This committee will jointly attempt to advise on ethical dilemmas outlined below.

Broad Ethical Dilemmas requiring CEC intervention

The Committee will use a multidimensional approach to advise on which patient should have access to a scarce resource using the principles outlined below:

[1] "Allocation of Scarce Critical Care Resources during the COVID-19 Public Health Emergency in South Africa" guidelines - published on https://criticalcare.org.za/wp-content/uploads/2020/06/V3-2020-May-05-Allocation-of-Scarce-Critical-Care-Resources-During-the-COVID-19-Public-Health-Emergency-in-South-Africa-FINAL-.pdf

[2] Western Cape Critical Care Triage Tool – published on https://www.westerncape.gov.za/assets/departments/health/COVID-19/western_cape_critical_care_triage_tool_version_1.2_14th_may.pdf

[3] "Triaging within the WC triage tool for Tygerberg Hospital (Final V1)_28 Dec 2020" guideline – provided to MCSA with the permission of Dr Nadiya Ahmed, the head of the Tygerberg Hospital Surgical ICU

[4] COVID-19 updated Treatment Escalation Support Teams, 15th May 2020. Version 1.1

1. At a critical point of care, when demand exceeds supply, such as when only one bed is available and there are two or more patients requiring this bed, measures will be activated to resolve this impasse. The hospital Triage Escalation Support Teams (TEST) are responsible to support with decisions on which of two or more patients who have the same clinical triage score will get, for example, allocation of the only ICU bed/ventilator/high flow oxygen device available. Should there be disagreement about this decision, stemming from either the patient, legally specified surrogate decision-maker[5], clinicians or hospital management, the ethical dilemma will be urgently referred to the CEC. The committee will then meet urgently and provide feedback to the referring triage team within 24 hours or sooner depending on the urgency of the dilemma.
2. The CEC decisions will be communicated back to the requesting entity (either the treating doctor or the TEST and/or Clinical Commander) at the hospital, based on the type of dilemma or situation at the hospital.
3. The other important decision that the CEC may advise on is de-escalation of care (e.g. from ICU to a ward or palliative care area). The CCSSA and other guidelines refer to ICU care as a trial of treatment. This means that if a patient, who has been on appropriate treatment, continues to deteriorate or fails to improve after regular, repeated clinical reviews, the possibility of de-escalating care may need to be considered if there is a bed shortage and other patients with a better prognosis are in need of this level of care and intervention. It is important that this possibility is communicated early to families by the treating doctor, and that admission to ICU is explained as a trial of treatment at the outset. Appropriate decisions about "do not attempt resuscitation" or "do not escalate care" as per MCSA policy should be agreed with the legally specified surrogate decision-maker and documented by the doctor.[6] Since MCSA has adopted the CCSSA triage guidance, the Western Cape Critical Care Triage Tool and the Tygerberg Hospital Triaging within the WC triage tool, any de-escalation of treatment will be in keeping with this guidance[7].
4. In the context of an evolving pandemic, the broad principles that will support ethics deliberations by the CEC will be fairness, justice, consistency, transparency and accountability.
5. Decisions will not be influenced by ability to pay, race, gender, religion or social status.
6. All public health ethics approaches to resource allocation have disadvantages. In a public health emergency, a utilitarian approach is commonly used to maximise benefit from limited resources. This usually aims to save the most lives and the most post treatment life years. Often, this means that younger, healthier patients are favoured while those with chronic underlying conditions, or those with poor access to health services and disabilities may be disadvantaged. Other approaches also carry disadvantages – random selection generally undervalues and trivialises human lives and a first come first served approach favours better resourced people and those who live closer to the health facility. The CEC will prioritise the utilitarian approach based on international broad consensus that this is considered most appropriate during the COVID-19 pandemic.
7. Where patients have exactly the same clinical triage score, the CEC will consider other factors based on the principles of reciprocal obligation and social justice and advise MCSA accordingly. Health care workers actively involved in the COVID-19 response will be prioritised due to the risk they are taking to help others and because, if saved, they

[5]Legally specified surrogate decision-maker as per the National Health Act for surrogate decision making are - spouse/partner, parents, grandparents, adult child, siblings- in that specific order.
[6] published on the MCSA nursing clinical guidelines intranet site on http://intranet/communities/nursing/GuidelinesAndPositionPapers/Clinical%20Guideline_Do%20not%20attempt%20resuscitation_%20Do%20not%20escalate%20care.pdf
[7] In individual cases in which concerns remain, treating clinicians are urged to consult their healthcare indemnity insurance team.

could potentially save many more lives in future. They are also regarded as a scarce human resource in South Africa. The life cycle approach could also be used where those who have not yet been through all the stages of the life cycle have higher priority.

Referral process

1. The hospital Triage Escalation Support Teams (TEST) are responsible to make the initial decision on triage or de-escalation processes for patients. Only in the event of disagreement about these decisions, stemming from either the patient, legally specified surrogate decision-maker, clinicians or hospital management, should the ethical dilemma be urgently referred to the CEC (see section 5 of the ToR).
2. Hospitals should identify and receive any queries or complaints related to ethical decisions through their existing channels and complete the COVID-19 Pandemic Ethical Concern referral form available on the Mediclinic website on https://www.mediclinic.co.za/en/corporate/about-mediclinic-southern-africa/ethics.html as comprehensively as possible. This can be done by the Clinician Representative, TEST team members or Clinical Commander. The patient/legally specified surrogate decision-maker would use the same online document to provide their appeal for CEC consideration, with the clinicians adding any additional information required by the CEC as requested.
3. An online submission of a COVID-19 Pandemic Ethical Concern will trigger an email notification to the office of the Chairperson of the CEC, Prof Keymanthri Moodley.
4. Feedback from the CEC will be sent back to the referring individual and copied to the treating doctor if this is appropriate given the context of the ethical dilemma.

Conclusion

The coronavirus pandemic is likely to affect our lives in South Africa and Namibia for the near future. The MCSA CEC members will endeavour to provide the necessary ethical guidance concerning the utilisation of scarce healthcare resources to the clinicians in the hospitals during this time.

Document compiled by Prof Keymanthri Moodley (Chairperson), with input from the CEC members:

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- Dr Ryan Davids
- Prof Eric Decloedt
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- Prof Mike James
- Prof Mosedi Namane
- Ms Bongekile Skosana

And Mediclinic Staff

- Dr Estelle Coustas
- Dr Kim Faure
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- Dr Tyson Welzel

ANNEXURE A

TERMS OF REFERENCE[8] FOR THE COVID-19 CLINICAL ETHICS COMMITTEE

Mediclinic Southern Africa

V1.10

24 March 2021

[8] These terms of reference were adopted from those of the Tygerberg Academic Hospital Clinical Ethics Committee, 2019.

Name of Committee	COVID-19 Clinical Ethics Committee (Co-CEC-MCSA)
Reports to	Divisional Chief Executive Officer (CEO)
Reports via	• Divisional Chief Clinical Officer (CCO) (normal clinical operations) • COVID-19 task team (disaster operations)
Function	• Advisory [Unless rendered instructive through an act of parliament or the presidency] • Consultative • Develop recommendations and review policy • Educational
Purpose	1. Early involvement and support for decision making that promotes and upholds respect for the dignity and rights of Mediclinic patients and health care workers. 2. Raise awareness of ethical aspects in resource allocations, promote fair resource allocation and stakeholder rights and interests. 3. To advise on priority setting, development of policies, principle guidelines, treatment limiting decisions / futility of care and criteria for best practice with senior clinicians as required. 4. To act as a consultative and resource base on urgent ad hoc clinical ethical issues to bridge clinical practice with higher level decisions for the division, its patients and staff.
Responsibility	1. To fulfil an advisory and consultative role with respect to clinical ethical dilemmas in Mediclinic facilities. 2. To advise on the development of protocols relating to clinical-ethical dilemmas in conjunction with relevant divisional and hospital staff. 3. To make recommendations to management at either a divisional, regional or facility level.
Core membership	The committee should be as independent as possible to neither be, nor appear to be driven by corporate agendas. Hence most of the membership should be constituted out of members either wholly un-associated with Mediclinic or at least not associated with the organisation structure of the Group or its divisions. At the same time, the representatives need to have ethical and clinical gravitas and be representative of our multi-cultural society. Members will have access to relevant strategic information and are bound by NDA, when applicable.
	• Mediclinic nursing representative • Mediclinic operations representative • Clinicians / Allied Health Care Workers from different specialties • Ethicists • Community / patient representatives • Interdenominational religious representative Members are appointed via the office of the divisional CEO.

1. CONSTITUTION

Committee chair	The **Chairperson** will be appointed by the Divisional CEO for as long as the National or local state of Disaster is in effect. If the Chairperson leaves before the end of the state of Disaster, the Divisional CEO will co-opt a new member to fill that place.
Ad hoc membership	• Relevant religious representatives will be consulted on a case-by-case basis. • Expert opinion will be sought from senior clinicians or other experts in specific fields. • Legal advice may be sought on an ad hoc basis by the Chairperson. • Clinical Management team member from the relevant facility.
Term of membership	Duration of the COVID-19 pandemic, for as long as the National or local state of Disaster is in effect. If a member leaves before the end of the state of Disaster, the Divisional CEO will co-opt a new member to fill that place. Where a conflict of interest exists, members must declare this and recuse themselves from deliberations on the specific matter or case.
Frequency of meetings	Monthly and on an ad hoc basis for urgent ethical dilemmas, as the need and referrals necessitate.
Quorum / Attendance	A quorum will consist of a core of three individuals for an urgent decision, made up of one ethicist, one clinician and one community representative.
Committee Administration	An administrative assistant will be co-opted by the Committee. This person will take minutes at the committee meetings.
Referrals	All referrals will be directed to the Chairperson via the administrative assistant who will have appropriate training. The Chairperson will screen and prioritise referrals according to their urgency and relevance. The administrative assistant will communicate with the CEC members to arrange a meeting. Referrals will be anonymised before being circulated to the CEC members.
Second opinions	A provincial clinical ethics committee with both public (Western Cape Government) and private (HASA) representatives has been set up as an "appeals body". This committee will only operate for the Western Cape. Anyone within the Western Cape Province who referred a case for consideration by Co-MCSA-CEC may seek a second opinion from the provincial committee. In addition, a patient or legally specified surrogate decision-maker may also seek a second opinion from the provincial committee. However, the provincial committee's recommendations also only remain advisory in nature.[9]

2. REPRESENTATIVENESS

The committee structure should be reviewed in relation to the representativeness of the population being served. The composition of the committee may need to be augmented regularly based on the particulars of the referral being addressed. For ad hoc ethical decision support relating to a particular patient's care, every effort should be made to ensure

[9] The provincial committee will serve for appeals for the Western Cape only. The availability and process within the Western Cape will be widely advertised.

the committee advising on the care best represents and understands the holistic needs of the patient with consideration given to their religious beliefs, healthcare directives and personal circumstances.

Mediclinic Southern Africa has patient advisory committees in existence that could be tapped into by the Committee.

3. TRAINING AND COMPETENCY REQUIREMENTS

To serve on the CEC, members should have received training and demonstrate competency in the following areas:

- Formal training in clinical ethics, and/ or
- Recognised leader in their respective field

4. REFERRAL CRITERIA

Examples of appropriate referrals:

- Uncertainty of Critical Care Triage teams and Triage Escalation Support Team (TEST) or similar body
- Uncertainty as to who should make health care decisions or how to make those decisions for patients too sick to speak for themselves
- Conflict between values or religious beliefs and a recommended course of treatment
- Disagreement over starting, continuing, or ending treatments, such as ventilation, feeding tubes
- Moral distress about a healthcare decision
- Controversial or experimental therapies

CEC should not be used for equipment / procurement or funding decisions. The CEC will also not review cases purely on the basis of a medico-legal review.

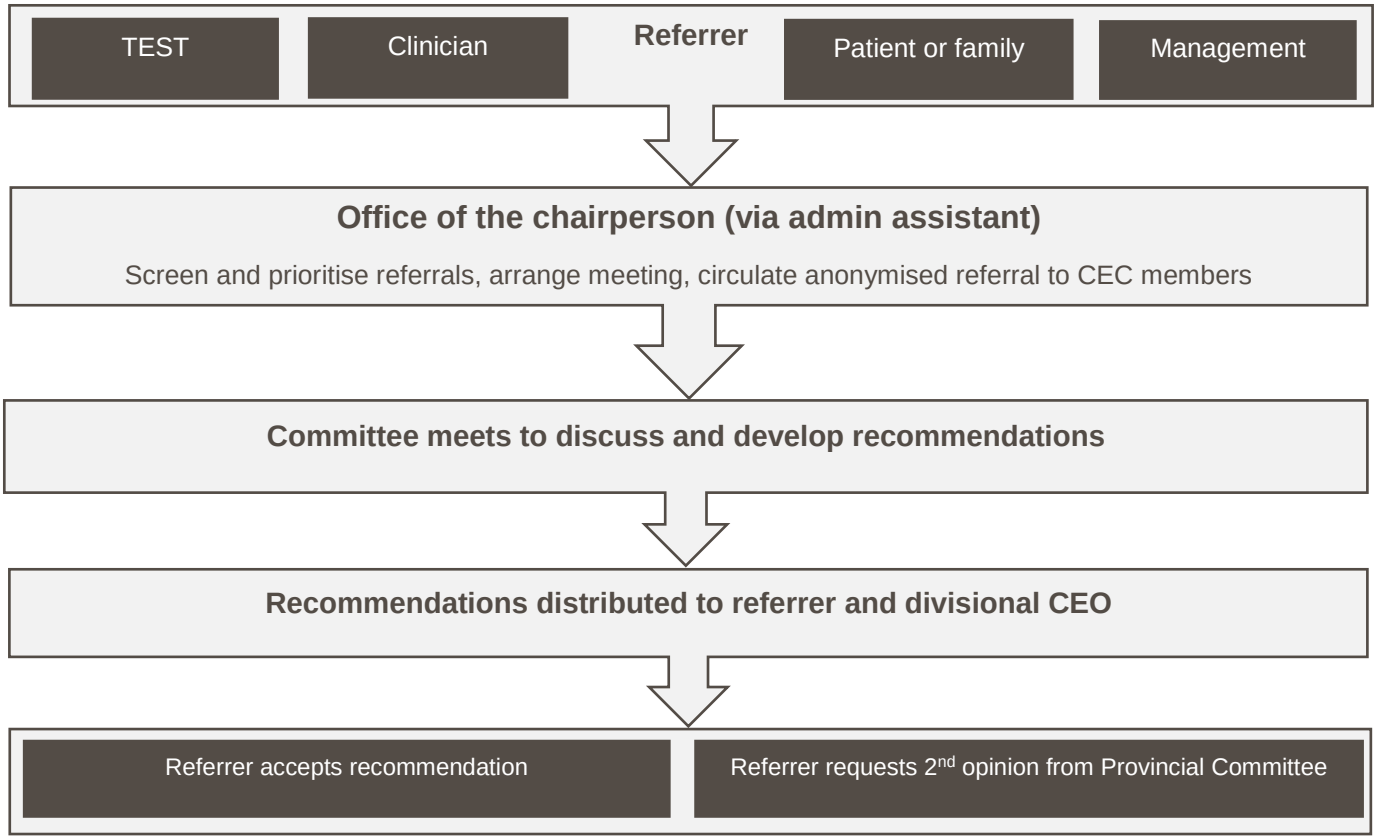
5. REFERRAL PROCESS

A number of referral pathways possible:

a) Referral from the Triage Escalation Support Team (TEST) or Clinical Performance Committee.
b) Direct referral by a clinician as a second opinion after having been considered by TEST
c) Referral from hospital or corporate management (most likely for policy or procedures) including the disaster command centres or representative
d) Direct referral from a patient or their legally specified surrogate decision-maker as a second opinion after consideration by TEST via existing structures (e.g. Patient Experience Manager).

In a case involving a specific patient or choice of patients:

- Discuss with patient, legally specified surrogate decision-maker and care team
- Discuss with hospital management team and consult local policies
- Referrer to complete on-line referral to CEC


TEST
Clinician
Referrer
Patient or family
Management
Office of the chairperson (via admin assistant)
Screen and prioritise referrals, arrange meeting, circulate anonymised referral to CEC members
Committee meets to discuss and develop recommendations
Recommendations distributed to referrer and divisional CEO
Referrer accepts recommendation
Referrer requests 2nd opinion from Provincial Committee

6. OPERATIONAL REQUIREMENTS

Agenda & **Documents**	An agenda for each meeting, together with relevant documentation will be forwarded to committee 24 hours before each meeting. For urgent consults documentation will be distributed on the day of the meeting. If possible, a summary of the ethical dilemma will be distributed electronically before the meeting by the Chairperson. As the committee is decentralised, meetings and discussions with families or other parties will be held via video- or teleconference. There will always be an attempt to get direct input from the treating clinician who made the request, as well as the local hospital clinical management team.
Minutes	Minutes of the meeting will be approved by the Chair and will be circulated to members with the agenda and documentation for the next meeting for ratification within 5 working days. The minutes of all meetings will be distributed on a confidential basis.
Recommendations and decisions	Under standard operations, the Mediclinic CEC is an advisory/ consultative body and not a prescriptive committee. Recommendations will be formulated via consensus. All committee deliberations will remain confidential. Recommendations will be minuted and forwarded to the divisional CCO for escalation to the divisional CEO. If legislation changes, or under a state of emergency the Mediclinic CEC may become an instructive body. If the divisional CEO disagrees with the recommendation of the CEC, the decision and the reason(s) for that decision should be communicated to the CEC in writing. However, the divisional CEO's decision remains final.
Confidentiality	All deliberations on the committee will remain confidential until such time as there is a need for an internal or external statement to be made via the Group or Divisional Communications departments. Case studies may emanate from committee deliberations and could be used as teaching material but must be anonymised prior to use. All core members and administrative staff will be required to sign confidentiality and non-disclosure agreements. The administrative assistant will be trained in matters regarding confidentiality.

7. INDEMNITY AND INSURANCE ARRANGEMENTS

The committee falls under the insurance cover of Mediclinic Southern Africa. Members will be covered for decisions emanating from this committee.