"SOPHIE'S CHOICE": HIV AND ICU ACCESS DURING COVID-19

OPSOMMING

"Sophie's Choice": MIV en intensiewesorgeenheid-toegang gedurende Covid-19

Die beperking van toegang tot skaars mediese sorg is 'n alledaagse realiteit in 'n land soos Suid-Afrika. Wanneer daar 'n pandemie soos COVID-19 uitbreek, is dit onvermydelik dat daar beperkings geplaas sal word op skaars mediese hulpbronne soos intensiewe-sorg-eenhede. Sulke rantsoenering is 'n gegewe regoor die wêreld, selfs in beter-toegeruste lande. In Suid-Afrika, waar die pandemie reeds meer as 'n honderd lewens geëis het, is dit belangrik dat kriteria daargestel sal word om toegang tot kritiese hulpbronne vir soveel as moontlike slagoffers van die pandemie te verseker.

Die aantekening ondersoek die moontlikheid dat MIV-status 'n rol kan speel in besluitneming oor wie toegang tot intensiewesorgeenhede sal verkry. Daar bestaan literatuur wat aandui dat, selfs voor die COVID-19-pandemie, mense wat met MIV saamleef, geneig was om aan die kortste end te trek waar pasiënte se toegang tot intensiewesorgeenhede gerantsoeneer moes word. Daar word aangevoer dat mediese kriteria alleen, en nie 'n veronderstelling dat mense wat met MIV saamleef 'n swakker kans het op oorlewing, gebruik moet word om toegang tot intensiewesorgeenhede regverdiglik te rantsoeneer. Die huidige stand van mediese kennis met betrekking tot verskillende groepe mense se vatbaarheid, en kanse op oorlewing, word gebruik as die agtergrond van 'n grondwetlike analise om hierdie argument te staaf.

1 Introduction

The rationing of scarce medical resources is an everyday reality in a country like South Africa where the public health care system often is unable to meet the demands of a population of close on 59 million people. Such rationing not just is a reality but becomes an absolute necessity when the country is dealing with the demands made upon its health care resources by the COVID-19 pandemic. Even the best-resourced countries battle to provide adequate intensive care unit (hereafter "ICU") facilities for the large numbers of patients needing admission and ventilation as a result of SARS-CoV-2 infection (see Lazzerini and Putoto "COVID-19 in Italy: Momentous decisions and many uncertainties" 2020 *The Lancet Global Health* e641 and Alam "Europe has 4,000 ICU beds for every million people. Parts of Africa have 5, health officials say" CNN 9 April 2020, available at https://edition.cnn.com/world/live-news/coronavirus-pandemic-04-09-20/h_0eaec491941d95dd9c2fde6ea36d674d (accessed 2-05-2020)).

The scarcity of health care resources amidst the COVID-19 pandemic creates the need for South African national and provincial governments to establish admission criteria that fairly apportion access to scarce but much-needed resources such as ICU facilities and beds. Ethicists describe the deliberation on who is given ICU access in these circumstances as "Sophie's choice" (see Bioethics Today "'Sophie's Choice' in the time of coronavirus: Deciding who gets the ventilator" available at http://www.bioethics.net/2020/04/sophies-choice-in-the-time-of-coronavirus-deciding-who-gets-the-ventilator/ (accessed 7-05-2020); and Cameron "Covid-19 ICU treatment: How SA doctors will CHOOSE who lives, dies – ethicist" BizNews 8 April 2020 available at https://www.biznews.com/inside-covid-19/2020/04/08/covid-19-icu-treatment-doctors-choose (accessed 30-04-2020).

"Sophie's choice" is a metaphor taken from a 1979 novel by American author William Styron which was the basis of a 1982 film of the same name. It describes an extremely difficult decision in a situation where no outcome is preferable over the other as both outcomes are equally desirable or equally undesirable)).

In light of the need to establish ICU access criteria during the COVID-19 pandemic, the note investigates the possibility that HIV-status may play a role in decision-making regarding who receives access to ICU facilities. HIV-status is singled out in light of the fact that literature exists that suggests that even in a situation where there is no pressing public health crisis such as the current pandemic in a tertiary public hospital in KwaZulu-Natal the presence of HIV infection was one of the factors associated with increased odds of being refused access to ICU. The study found that malignancies and HIV positivity increased the chances of refusal of ICU access more than two-fold (Gopalan and Vasconcellos "Factors influencing decisions to admit or refuse patients entry to a South African tertiary intensive care unit" 2019 *SAMJ* 645–651).

This evidence of exclusion from ICU access of persons living with HIV even in the absence of the COVID-19 pandemic indicates that the stigma associated with HIV infection likely may be a consideration in decisions considering who should access scarce resources such as ICU facilities during the COVID-19 pandemic. At this point, I stress that existing South African guidelines governing ICU access (which predate the COVID-19 pandemic) do not use HIV status as a basis for limiting access (see, eg, Joynt *et al* "The Critical Care Society of Southern Africa Consensus Statement on ICU Triage and Rationing (ConICTri)" 2019 *SAMJ* 613). However, if these guidelines are regarded as insufficient in the present circumstances, they may be amended and include HIV status. As well, as the study mentioned above shows, health care workers do not always follow these guidelines.

It is well-known that persons living with HIV in South Africa are vulnerable to discrimination and exclusion. Discrimination based on HIV status and HIV-related stigma occurs in multiple settings, including employment, insurance, education, and health care (see UNAIDS "Agenda for zero discrimination in health care settings" 2017 available at https://www.unaids.org/sites/default/files/media_asset/2017ZeroDiscriminationHealthCare.pdf (accessed on 2-05-2020)). Persons living with HIV are marginalised and stigmatised by their families and communities and often experience various of their human rights being violated. The South African Constitutional Court held as follows with regard to the plight of persons living with HIV in South Africa (*Hoffmann v South African Airways* 2001 (1) SA 1 (CC) (hereafter "*Hoffmann*") para 28):

> "Society has responded to their plight with intense prejudice. They [persons living with HIV] have been subjected to systemic disadvantage and discrimination. They have been stigmatised and marginalised. As the present case demonstrates, they have been denied employment because of their HIV positive status without regard to their ability to perform the duties of the position from which they have been excluded. Society's response to them has forced many of them not to reveal their HIV status for fear of prejudice. This in turn has deprived them of the help they would otherwise have received. People who are living with HIV/AIDS are one of the most vulnerable groups in our society. Notwithstanding the availability of compelling medical evidence as to how this disease is transmitted, the prejudices and stereotypes against HIV positive people still persist."

In light of the possibility that once again the rights of persons living with HIV may be infringed when decisions are made on ICU access in the COVID-19

pandemic, the note investigates whether such a limitation is constitutionally valid in the hope of limiting the exposure of persons living with HIV to discrimination, marginalisation, a denial of their rights and to abuse.

Below, a brief outline is given of a few medical facts that are known about COVID-19 infection. Thereafter, the clinical evidence is examined to determine whether HIV-infection poses a greater risk for COVID-19 infection, and increased morbidity once infected. A constitutional analysis is undertaken of the potential limitation of the right of persons living with HIV to ICU facilities. The note concludes with a number of observations.

2 SARS-CoV-2 or COVID 19 infection

Reports of a new corona virus infection surfaced in China in late-2019. Corona viruses are large single-stranded RNA viruses which can infect both animals and humans (Weiss and Leibowitz "Coronavirus pathogenesis" 2011 *Advances in Virus Research* 85). Corona viruses cause respiratory, gastrointestinal, hepatic, and neurologic symptoms (*ibid*). New coronavirus-subtypes emerge in humans from time-to-time, mainly due to there being so many of the virus (in scientific terms their high prevalence) and their wide distribution (Cui *et al* "Origin and evolution of pathogenic coronaviruses" 2019 *Nature Reviews Microbiology* 181). Corona viruses seem to thrive in settings where there is an increase in activities which bring humans in close proximity to animals (*ibid*).

Originating in the city of Wuhan in China, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2 or COVID-19) spread to the populations of almost all countries around the globe which prompted public health responses that brought economies to a standstill and have cost thousands of lives while health care systems battle to bring the pandemic under control (see, generally, "WHO statement on cases of COVID-19 surpassing 100 000" available at https://ww.who.int/news-room/detail/07-03-2020-who-statement-on-cases-of-covid-19-surpassing-100 000 (accessed 30-05-2020). COVID-19 infection has a fatality rate of 2–3 per cent (Wu and McGoogan "Characteristics of and important lessons from the coronavirus disease 2019 (COVID-19) outbreak in China: Summary of a report of 72 314 cases from the Chinese Center for Disease Control and Prevention" 2020 *JAMA* 2648 and Wu *et al* "The SARS-CoV-2 outbreak: What we know" 2020 *International Journal of Infectious Diseases* 44). The rate of fatalities is higher among elderly patients and patients with co-morbidities (Wu and McGoogan 2649). Person-to-person transmission is regarded as efficient by scientists and accounts for the rapid spread of the disease (Chen and Li "SARS-CoV-2: Virus dynamics and host response" 2020 *The Lancet Infectious Diseases* 515). Patients with COVID-19 experience respiratory symptoms similar to other respiratory virus infections (*ibid*).

So-called "co-morbidities" (in other words, factors which are associated with worse health outcomes, more complex clinical management and increased health care costs) most commonly associated with an adverse outcome in patients who have COVID-19 are hypertension, diabetes, cardiovascular disease, chronic obstructive pulmonary disease, chronic kidney disease, and malignancy (see Guan *et al* "Comorbidity and its impact on 1590 patients with Covid-19 in China: A Nationwide Analysis" 2020 *European Respiratory Journal* available at https://doi.org/10.1183/13993003.00547-2020 (accessed 30-04-2020); and Zhou *et al* "Clinical course and risk factors for mortality of adult inpatients with

COVID-19 in Wuhan, China: A retrospective cohort study" 2020 *The Lancet* 1054). Older age was shown to be a significant risk factor for death in patients admitted to hospital, significantly increasing the odds of in-hospital death with each added year of age (Zhou *et al* 1061).

In most persons, COVID-19 infection causes relatively mild, transient symptoms; in others, especially those who have one or a combination of the above-mentioned co-morbidities, hospitalisation is required and in most severe cases ICU treatment, including mechanical ventilation (Murthy *et al* "Care for critically ill patients with COVID-19" 2020 *JAMA* 1499). ICU treatment is expensive, labour-intensive and a specialised form of health care (see also, generally, Rossouw *et al* "Comorbidity in context: Medical considerations around HIV and TB during the COVID-19 epidemic (Part I)" 2020 *SAMJ* (forthcoming)).

3 HIV and COVID-19 infection

In 2018, approximately 7.7 million persons were living with HIV infection in South Africa (see UNAIDS "South Africa" available at https://www.unaids.org/en/regionscountries/countries/southafrica (accessed 01-05-2020)). South Africa has the largest HIV antiretroviral (hereafter "ARV") roll-out programme in the world, with approximately 62 per cent of adults receiving ARVs and 63 per cent of children on ARV treatment (*ibid*).

No study as yet indicates that people living with HIV are at greater risk of COVID-19 infection or has indicated that once infected with COVID-19, HIV co-infection increases morbidity. In light of this paucity of evidence, the European AIDS Clinical Society and the British HIV Association issued a joint statement affirming that currently no evidence suggests that HIV infection alone predisposes to exhibiting a greater risk of infection with SARS-CoV-2 or worse outcomes for COVID-19 (British HIV Association "Coronavirus (COVID-19) and HIV – Responses to common questions from the British HIV Association (BHIVA)" 19 March 2020, available at https://www.bhiva.org/coronavirus-and-HIV-responses-to-common-questions-from-BHIVA (accessed 2-05-2020); also see Rossouw *et al*).

In fact, some probability suggests that HIV-infected patients on ARV treatment may be protected against COVID-19 infection due to the antiviral effect of ARVs (Chen *et al* "Lack of severe acute respiratory syndrome in 19 AIDS patients hospitalized together" 2003 *Journal of Acquired Immune Deficiency Syndromes* 242). Therefore, any suggestion that persons living with HIV should be excluded from ICU access because of the mere fact that they are living with HIV is lacking any scientific basis.

4 Constitutional analysis

The South African Bill of Rights guarantees the right of 'access to health care services' (and not the right to health that is guaranteed in many international human rights instruments) in section 27(1)(a). Of course, this guarantee is not absolute: it is impossible in a developing country such as South Africa to provide for everyone's needs and therefore limitations are placed on the right in terms of section 27(2) and in accordance with the general limitations clause in section 36 of the Constitution. It ought to be remembered that the right of access to health care services should not be viewed in isolation as many rights in the Bill of Rights bear on the rationing of scarce resources; examples are the right to equality

(section 9), to dignity (section 10), life (section 11) and the right to physical integrity (section 12).

Section 27(2) of the Constitution enjoins the state to 'take reasonable legislative and other measures, *within its available resources*, to achieve the *progressive realisation* of each of these rights' (my italics). The right of access to health care services, as is the case with other so-called socio-economic rights, therefore is realisable only over time and in accordance with the availability of the state's resources. However, the right to emergency health-care services is not subject to limitation – it appears to be immediately enforceable since, according to section 27(3), no one 'may be refused emergency medical treatment'.

'Emergency medical treatment' is not defined either in legislation or case law but in line with the *dictum* in *Soobramoney v Minister of Health (KwaZulu-Natal)* 1998 (1) SA 765 (CC) (hereafter "*Soobramoney*"). It is doubtful that continuous and sustained ICU care for Covid-19 patients will be interpreted by the courts as constituting 'emergency medical treatment' (in *Soobramoney* the court found that continuous dialysis treatment for a chronic disease does not amount to "emergency medical treatment" (para 44)).

Because of their abstract nature, the human rights guaranteed in the Constitution have meaning only when interpreted by the courts in concrete situations. The South African Constitutional Court has decided several cases which deal with access to resources; a case that is pertinent in the present discussion is *Government of the Republic of South Africa & Others v Grootboom & Others* 2001 (1) SA 46 (CC) (hereafter "*Grootboom*"). *Grootboom* dealt with vulnerable persons' access to housing, which is realisable progressively as is the right of access to health care services. In order to assess whether the state's measures to ensure the progressive realisation of the right were adequate in this instance, the Constitutional Court formulated a 'reasonableness' standard which ensures access to be 'comprehensive', 'coherent', 'balanced' and 'flexible' and 'non-discriminatory' (*Grootboom* paras 40–43) as a 'programme that excludes a significant segment of society cannot be said to be reasonable' (*Grootboom* para 43). Evidently, policy decisions which determine COVID-19 patients' access to ICUs must adhere to the standard of reasonableness. Significantly, the Constitutional Court stated those 'whose needs are most urgent and whose ability to enjoy all rights is therefore most in peril, must not be ignored by the measures aimed at achieving realisation of the right' (*Grootboom* para 44). It is submitted that as the necessity of COVID-19 patients to access ICU services literally may be considered a life-and-death matter, their need certainly qualifies as 'most urgent' as contemplated by the court.

The requirement that a 'programme that excludes a significant segment of society cannot be said to be reasonable' (*Grootboom* para 43) in relation to access to ICU facilities is in keeping with the wording of section 27(1)(a) which guarantees the right of access to health care services to 'everyone'. The use of 'everyone' in this context may be interpreted to mean that decisions taken on which patients' have access to ICU services may not be discriminatory based on those patients' HIV status. As well, the rights in the Bill of Rights are considered to be interrelated, thus the right to life as guaranteed in section 11 of the Constitution can be used to argue that as a limitation on HIV patients' access threatens their survival, their right to life is unconstitutionally limited.

Section 9 of the Constitution guarantees the right to equality. The section enumerates the grounds upon which people may not be discriminated against unfairly. The test for determining whether law or conduct amounts to unfair discrimination was developed in *Harksen v Lane NO and Others* 1997 (11) BCLR 1489; 1998 (1) SA 300 (CC) (hereafter "*Harksen*"). According to *Harksen*, first it must be determined whether the law or conduct at issue differentiates between persons. If there is differentiation (such as not allowing access of certain groups of people to ICU facilities), it must be determined if such differentiation bears a rational connection to a legitimate government purpose. Second, it must be considered whether the differentiation amounts to discrimination, and whether the discrimination is fair. If the differentiation is on a ground listed in section 9 of the Constitution, then it amounts to discrimination and is presumed to be unfair. If it is not on a listed ground, whether or not it is found to be discrimination depends on the potential of the measure to impair the human dignity of persons.

HIV status is not a listed ground in section 9 of the Constitution. However, the Constitutional Court in *Hoffmann* held that HIV status amounts to an analogous ground, as discrimination on the basis of a person's HIV status impacts negatively on a person's dignity and is based on an 'ill-informed prejudice' (see the quotation in para 1 above from *Hoffmann*)).

The National Assembly has enacted legislation that gives effect to section 9 of the Constitution in the form of the Promotion of Equality and Prevention of Unfair Discrimination Act (Act 4 of 2000; hereafter "PEPUDA"). The Preamble of PEPUDA highlights that discrimination often is systemic in nature:

> "The consolidation of democracy in our country requires the eradication of social and economic inequalities, especially those that are systemic in nature, which were generated in our history by colonialism, apartheid and patriarchy, and which brought pain and suffering to the great majority of our people."

In holding that neither the state nor individuals may unfairly discriminate against any person, PEPUDA defines discrimination as:

> "any act or omission, including a policy, law, rule, practice, condition or situation which directly or indirectly:
> (*a*) imposes burdens, obligations or disadvantages on; or
> (*b*) withholds benefits, opportunities or advantages from, any person on one or more of the prohibited grounds".

PEPUDA contains a schedule that encompasses an "illustrative list of unfair practices in certain sectors" in section 29. Under "3(c) Health care services and benefits" it lists "[u]nfairly denying or refusing any person access to health care facilities . . .". The relevance to the present discussion of the inclusion of this action as an example of an unfair practice is self-evident.

Returning to the constitutional analysis, in the case of the non-admission of people living with HIV to ICU facilities such conduct clearly differentiates between people based on their HIV status. In determining whether such differentiation amounts to discrimination, although not a constitutionally-listed ground, the Constitutional Court clearly recognises HIV status as an analogous ground (cf *Hoffmann*). It is submitted that the denial of the benefit of ICU-access in the case of persons living with HIV amounts to unfair discrimination. Those who are discriminated against in this instance may die as a result of non-admission to ICU facilities.

But human rights are not absolute – they are subject to limitation in certain defined circumstances. The right to equality and the right of access to health care

services in section 27(1)(a) of the Constitution are subject to the general limitations clause: section 36 of the Constitution determines that any law of general application which attempts to limit a constitutional right must be "reasonable and justifiable in an open and democratic society based on dignity, equality and freedom".

Further, section 36 dictates that an inquiry into whether a limitation is justifiable includes a proportionality assessment, referencing factors such as the nature of the right, the purpose of the limitation, the extent to which it limits the right in question and whether it is possible to achieve the purpose of the limitation in a less restrictive manner. Applying the proportionality assessment to criteria for ICU admission that bar persons living with HIV from ICU access, clearly demonstrates that refusal is not constitutional for the reasons outlined below.

Section 36(1)(a) requires an analysis of the nature of the right that is sought to be limited. A denial of access to ICU facilities potentially deprives persons living with HIV of their right to life as ICU access saves lives. Therefore, it is an important right which stands to be limited, as also are the rights to equality and access to health care services.

Section 36(1)(b) focuses on the importance of the purpose of the limitation; in the context of limited health care resources during a pandemic the rationing of resources is an important aim as it is impossible to supply everyone's need. Indeed, measures enforcing reasonable and rational medical or scientific grounds for ICU access are acceptable but, as shown in paras 2 and 3 above, limiting the ICU access of patients living with HIV does not have a rational medical or scientific basis.

As far as section 36(1)(c) is concerned, which enquires as to the nature and extent of the limitation, potentially the limitation is severe if it includes a blanket ban on all persons living with HIV and ignores their individual medical circumstances. The denial of access to ICU facilities impacts on the right to life and human dignity and severely affects the victim.

In terms of section 36(1)(d), the relation between the limitation and its purpose, on the evidence provided, means it is unlikely that prohibiting access on non-scientific or prejudicial grounds achieves the purpose of distributing limited health care resources to those most in need.

Finally, in terms of less restrictive means to achieve the purpose (section 36(1)(e)) there are other means than imposing a ban on persons living with HIV from accessing ICU facilities, for example, patients with potential co-morbidities can be assessed based on their particular medical histories as well as the available scientific and medical evidence without specifically targeting persons living with HIV.

From the above analysis, clearly measures which prohibit people living with HIV from accessing ICU facilities are unconstitutional and void. Put differently, the restriction of the right of people living with HIV to equal access to health care services is not proportional to the aims supporting the restriction. Clinical facts and associated medical criteria alone are relevant in determining whether or not a particular person qualifies for access to ICU in specific circumstances, such as the COVID-19 pandemic.

5 Conclusion

It should be remembered that the rationing of scarce medical resources seldom relies solely on clinical or scientific evidence (see Pieterse "Health care rights, resources and rationing" 2007 *SALJ* 514). Rationing decisions are made in the context of political or administrative choices (as is illustrated in the discussion of the *Grootboom* case above). Decisions based on non-medical or non-clinical aspects, such as a political or social agenda, stigma or preconceived ideas about HIV patients' ability to fight COVID-19 infection, are unconstitutional and are therefore void. In this context, Marius Pieterse states: "most societies increasingly contend that rationing decisions and processes should be based on visible and consistent criteria, should be capable of rational justification and should be subjected to objective scrutiny, so as to ensure that they resonate with values of accountability, equity and fairness". It follows that objective medical criteria and scientific evidence only may be used to decide access to ICU facilities in the time of COVID-19. Decisions of this nature likely will be a "Sophie's choice"; nevertheless it is a choice that should be exercised in light of the available scientific evidence.

The available medical evidence (discussed in para 3 above) shows that people living with HIV are not at greater risk of contracting COVID-19 nor is it that persons living with HIV suffer increased morbidity once infected with COVID-19. Therefore, persons living with HIV must not be refused access to ICU facilities during the COVID-19 pandemic merely because of their HIV-positive status.

Persons living with HIV in South Africa have experienced discrimination, stigmatisation and prejudice for over four decades. It is hoped that the denial of access to ICU facilities will not be an added item to their suffering.

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