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COVID-19: collateral effects on patients seeking ENT services at Chris Hani Baragwanath Academic Hospital

Since lockdown on 27 March 2020 to prevent COVID-19 infections from overwhelming the hospital systems, public health facilities and most private hospital groups have scaled down on elective surgery and non-emergency outpatient visits. The Ear, Nose and Throat (ENT) fraternity in SA was no exception and has followed the recommendations of several international ENT groups to cease all elective work.1,2 However, it is axiomatic that in some conditions, particularly cancer, the longer patients wait the worse the prognosis. Other reports have indicated that patients cur-rently experience fear and anxiety of becoming infected with COVID-19 if they attend hospital.3 Hence it is important that this drastic reduction in routine activities be documented so that it can inform health policy to plan for the short and long term effects of the lockdown and phased return to "normality". The impact of patients' concerns has already been demonstrated in other specialities.4 We report on the effects of the COVID-19 pandemic on ENT services at Chris Hani Baragwanath Academic Hospital (CHBAH) in South Africa and the ethical considerations they pose.

CHBAH is a 3 200-bed hospital affiliated with the University of the Witwatersrand situated on the outskirts of Soweto that provides tertiary ENT services to a huge catchment area, including much of the provinces of Gauteng (11.4 million) and North West (3.7 million).[5] The ENT and Head and Neck division annually consults with 12 000 outpatients, admits 1 500–1 600, patients and performs 1 200 surgical procedures.

When the lockdown was implemented, the ENT department at CHBAH drew up a protocol to triage and prioritise patients attending our department. This entailed a staff sparing, rotating system to minimise COVID-19 infection risk to our staff and the restriction of attendance to only emergencies and cancer surgery patients.

We aimed to assess the impact of COVID-19 infection on admissions and theatre procedures on our department by reviewing the admission and theatre records for the periods 17 February–26 March 2020 and 27 March–4 May 2020. This included 39 days either side of the lockdown. In the 39 days before the lockdown 143 patients were seen: 109 (76%) were adults and 34 (24%) paediatric. Emergencies in adults accounted for 48 patients (44%), whilst the remaining 61 (56%) were elective patients. Of the paediatric admissions, 14 (41%) were emergencies, and 20 (59%) were elective admissions.

After the lockdown, admissions were 38% of the pre-lockdown period under study. Of these patients, 36 (67%) were adults and 18 (33%) were paediatric. Emergencies in paediatric patients accounted for 11 patients (61%), and in adults 34 (94%) of patients. Elective admissions among the paediatric population totalled only 7 patients (39%). Adults had 2 elective admissions (6%). In total, emergencies accounted for 43% of admissions pre-lockdown, and 83% of admissions during the lockdown. One patient had his surgery cancelled on the day lockdown was implemented.

Emergency non-surgical paediatric admissions were the same pre- and post-lockdown: 9 and 10 respectively, and were predominantly related to infective conditions that required monitoring. This was in contrast to elective paediatric non-surgical admissions which were nil in both situations. In adults the emergency non-surgical admissions pre- and post-lockdown were 39 and 17 and were largely due to severe tonsillitis and other infections. Elective non-surgical admissions were under 10 in both settings and were largely due to advanced stage cancers. Paediatric emergency surgery admissions were again due to advanced infections or foreign bodies and numbered 2 and 5 pre- and post-lockdown. Paediatric elective surgery was severely curtailed from 34 to 5 pre- and post-lockdown respectively with approximately 66% being tonsillectomies pre-lockdown compared to none post-lockdown. Adult emergency surgery doubled from 4 pre-lockdown to 8 cases post-lockdown for a variety of conditions. Adult elective surgery was reduced from 56 to 22 cases. Staging panendoscopy for cancer accounted for over a third of cases pre-lockdown with only half that number post-lockdown.

The ethical implications of lack of access to healthcare for conditions not related to COVID-19 are of concern during this pandemic, particularly for patients who attend CHBAH and similar tertiary state institutions. These patients are already marginalised and vulnerable because of their socioeconomic status and the COVID-19 pandemic has increased this vulnerability.[6]

The results show the sharp contrast between elective surgery and admissions pre- and during lockdown. This 63% reduction is not surprising considering *inter alia* the triage and priority setting policy adopted by the department. Even when considering emergency admissions, there was a notable decline in actual numbers after the lockdown was instituted. In addition, it is of concern that the number of patients presenting with cancer also declined even though seeking medical help was a specific exclusion when the government issued orders encouraging everyone to stay at home. It is probable when the lockdown is lifted, that a flood of elective cases and patients presenting with advanced cancer will present to our service. It is hoped that this will not overwhelm the system as was expected with COVID-19 cases.

The reasons for patients not accessing healthcare are multifactorial. Instructions given were probably not clear enough as most patients stayed away, including those who had cancer as evidenced by our study. Moreover, even if patients wanted to go to hospital, they might have been fearful of contracting the coronavirus infection in the hospital. In addition, a vast majority of our patients rely on minibus taxis for transport. Initially, these were not allowed to operate at all, and later were severely restricted. Policies passed by the government during this period definitely impeded access to essential healthcare. Policies limiting access to healthcare during pandemics must be cognizant of the unintended consequences of such restrictions. Furthermore, it would be difficult to defend such limitations as reasonable and justifiable even if section 36 of the Bill of Rights of the Constitution were to be applied.[7] While preparing for the surge, it is submitted that patients were denied necessary treatments, and in some cases, patients waiting for their elective treatments following the lockdown, developed into emergencies with resultant associated morbidity.

It is also possible that patients, of their own volition, felt that they did not want to overwhelm the system. Furthermore, anecdotal evidence from social media and radio is that many people express anxiety about attending any public place, including schools and hospitals. It is possible that, in seeking to avoid contracting COVID-19, they forego treatment for other diseases such as cancer. Garcia et al. reported in their study that patients with heart conditions delayed seeking medical help during the COVID-19 pandemic. They saw a significant drop in the number of patients presenting for primary percutaneous coronary intervention.[3] They partially attribute this decrease in presentation to the US hospital system and to possible patient-based anxiety.

It is correct that the government allocates resources to the pandemic, but this should not be at the expense of patients that require necessary medical care and who are not infected with the virus. These patients have basic needs and rights that are enshrined in the Constitution.7 The Constitutional promise of fair allocation of resources applies even during pandemics. It would also be prudent of government, the media, NGOs, and healthcare workers to ensure that people have sufficient and relevant information to make decisions regarding their health in the face of the pandemic. The manner in which a pandemic is addressed must take into consideration not only possible collateral harms, but also plans for addressing these during lockdown and post-lockdown periods. As the lockdown eases it is advisable that hospitals adopt a pragmatic approach and put into motion processes to deal with the realistic expectation of a surge of patients whose treatments have been put on hold.

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