

COVID-19: ‘A pandemic of the unvaccinated’? – compassion fatigue among healthcare professionals in South Africa

Rationing of scarce resources is the cornerstone of healthcare in low- to middle-income countries (LMICs) across the globe. For many healthcare professionals in the Global South, it is an all-too-familiar challenge, predating the COVID-19 pandemic. Triage and priority setting were simply scaled up and assumed a new dimension during the current pandemic.^[1]

Although early pandemic debates in South Africa (SA) centred around access to critical care,^[1] deliberations soon expanded to vaccine access and roll-out.^[2] After a vaccine roll-out plan was instituted in the form of an implementation study on healthcare professionals at greatest risk,^[3] roll-out progressed to the elderly and selected essential workers. Thereafter vaccine distribution expanded to various age groups, and currently anyone in SA aged ≥ 18 years is eligible for vaccination. Over 17 million doses have been administered to date (4 October 2021), and $\sim 14\%$ of the population ($\sim 21\%$ of adults) is fully immunised with either a single dose of the Johnson & Johnson vaccine or two doses of the Pfizer vaccine.

As vaccine supply increases in SA, vaccine uptake is improving despite the anti-vaxxer movement fuelling vaccine hesitancy, predominantly via social media platforms frequented by many with low levels of health literacy. Healthcare professionals are engaging with communities at various levels to promote balanced messaging on vaccines and to correct misperceptions. Despite these efforts, those who are strong proponents of individual rights fail to understand the public health imperative to act in the public interest during this health crisis. A public health ethics approach supports limitation of individual rights for the greater good and promotion of solidarity. The SA Constitution^[4] likewise requires a careful weighing and balancing of individual liberties, all of which may be limited when necessary and justifiable. Consequently, vaccine mandates are being promoted and implemented, mainly in private organisations.^[5] Incentives are also being offered by retail outlets, but although less restrictive than vaccine mandates, these are nothing more than a behavioural strategy that temporarily increases health-promoting behaviours by 2 - 5 percentage points on average.^[6] They work with variable efficacy outside of public health crises, but are not sufficiently powerful to drive vaccine uptake at the scale required to bring the pandemic under control to the same extent as vaccine mandates, which may increase vaccine uptake by ~ 18 percentage points.^[7]

As most patients requiring hospitalisation and critical care are currently unvaccinated,^[8] healthcare professionals are understandably becoming less tolerant of those who refuse vaccines despite counselling and access. This lack of tolerance, and in some cases compassion fatigue, is playing itself out on social media platforms with uncharacteristic messaging by professionals. These messages range from descriptions of COVID-19 now as ‘a self-inflicted pandemic’ to social media communications advising the public to stay at home and treat themselves should they become infected with COVID-19. The US Centers for Disease Control and Prevention director has described COVID-19 as a ‘pandemic of the unvaccinated’.^[9] Globally, some doctors are conducting telehealth consultations with the unvaccinated to protect themselves, their staff and vaccinated patients in their practices. Some are referring unvaccinated patients to other healthcare providers, citing conscientious objection to treating those who decline COVID-19 vaccines in the absence

of medical contraindications. These messages to the public are increasing in frequency in SA.^[10]

What is adding to compassion fatigue is the vulnerability that many healthcare professionals face with their own waning immunity, despite being vaccinated, in the context of more virulent variants such as delta. A prolonged third wave has exacerbated physical, emotional and mental exhaustion. In many LMICs, healthcare professionals are not being prioritised for booster vaccine shots despite breakthrough infections 6 months after vaccination, while vaccine roll-out proceeds to younger healthy citizens.^[11] Healthcare professionals in high-income countries, in comparison, are being considered for boosters.

Although to date critical care triage criteria have not included vaccine status, there is growing discussion around this potential dilemma when critical care beds become severely limited during subsequent waves and many patients (vaccinated and unvaccinated COVID-19 and non-COVID-19 patients) may be competing for the last bed in an intensive care unit (ICU). If the basis for triage criteria revolves around prognostic factors, it can be argued that a vaccinated person may have a better chance of recovery from severe COVID-19 than an unvaccinated person, all other factors being equal. Such a decision is complex and logistically challenging, requiring documented reasons for declining vaccines in medical records and documented counselling efforts by health professionals where medical contraindications do not exist. Where such information is not available, using vaccination status as a triage criterion may not be defensible. Very few vaccinated patients, however, are developing severe disease. What remains concerning is the number of patients with non-COVID-19 illnesses requiring critical care who may be denied access to ICUs and high-care facilities that are full of unvaccinated patients with COVID-19.

Many of these difficult decisions in healthcare are unprecedented, but so is the scale and intensity of the pandemic, the degree of mental and physical exhaustion, and the extent of compassion fatigue. All these negative consequences are experienced more acutely by the healthcare profession in LMICs, who have waited longer for vaccines than other countries in the Global North. Professional bodies globally have set high standards for the profession, mostly in the context of pre-pandemic times. While no healthcare professional may refuse medical treatment in an emergency, the scenario of elective treatment during a public health crisis such as the current pandemic raises fresh ethical challenges and deliberations on the extent to which professional boundaries may be stretched. The medical establishment has endured a long history of sacrificial expectations to treat without fear or favour, and to serve unconditionally. These expectations lay healthcare professionals open to exploitation by the public and by employers in the public health sector. The boundaries between duty, exploitation and abuse of the healthcare profession are becoming blurred, with profound implications for healthcare during the impending fourth wave and beyond the pandemic.

K Moodley

*Centre for Medical Ethics and Law, Department of Medicine,
Faculty of Medicine and Health Sciences, Stellenbosch University,
Cape Town, South Africa
km@sun.ac.za*

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S Afr Med J. Published online 4 October 2021. <https://doi.org/10.7196/SAMJ.2021.v111i11.16142>