

When patients refuse COVID-19 testing, quarantine, and social distancing in inpatient psychiatry: clinical and ethical challenges

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Received 22 June 2020

Accepted 2 July 2020

Published Online First

10 July 2020

ABSTRACT

The COVID-19 pandemic has introduced new ethical challenges in the care of patients with serious psychiatric illness who require inpatient treatment and who may have been exposed to COVID-19 or have mild to moderate COVID-19 but refuse testing and adherence to infection prevention protocols. Such situations increase the risk of infection to other patients and staff on psychiatric inpatient units. We discuss medical and ethical considerations for navigating this dilemma and offer a set of policy recommendations.

CASE

A 26-year-old man with a history of schizophrenia is brought to the emergency room by police from a men's shelter where there has been an outbreak of COVID-19. He has been behaving bizarrely over the course of several days, building a barricade around his bed and loudly threatening peers and staff who approach him. He is dishevelled, observed talking to himself and engages in odd movements reminiscent of martial arts. On arrival to the emergency room, the patient does not permit vital sign measurement, physical examination or routine laboratory testing. He does not want anyone touching him or sticking things into him. He does not make eye contact and continues an incoherent banter, intermittently assuming a menacing posture when approached. The patient is maintained in a single room in the emergency room for several days, awaiting 'medical clearance', in preparation for involuntary admission to a psychiatric hospital.

Attempts to engage him and explain the need for medical evaluation including COVID-19 testing are unsuccessful. Antipsychotic medications are likewise refused. The patient is encouraged to wear a mask and remain in his room because of a concern that he was exposed to individuals with COVID-19 at his shelter and may himself be infected. He does not comply. He is repeatedly verbally redirected to return to his room. All staff in the area wear full personal protective equipment (PPE) and visitors are not permitted in the area. The patient does not appear to be exhibiting common symptoms of COVID-19—no sweating, cough or shortness of breath. The patient is admitted to a general psychiatric unit, given a single room and asked to remain there pending COVID-19 testing and encouraged to wear a mask. The patient arrives on the unit and refuses to remain in his room or wear a mask. Using a variety of techniques, staff attempt to engage the patient but are unsuccessful. The patient wanders freely about the unit.

CAPACITY, AUTONOMY AND COVID-19

This hypothetical case is a composite of a number of actual ones. These cases are clinically and ethically complex because they involve patients with serious psychiatric disorders who often lack capacity to make a reasoned judgment about refusing assessment, who may be at significant risk of COVID-19 and who, because of the effects of their psychiatric illness, are unable to fully adhere to the requirements for COVID-19 testing or isolation protocols, including wearing a mask and room restriction.

The seriousness and urgency of this scenario are amplified by the fact that these individuals are treated in locked facilities, living in close quarters with dozens of other patients and staff. Because conditions in psychiatric hospitals create a heightened risk of infection, the decision to admit a patient, either involuntarily or voluntarily, must take this serious concern into account.¹ Strategies to mitigate the risk of infection on psychiatric inpatient units may include universal testing, wearing masks, social distancing and related interventions.²

As we know from the thousands of deaths in nursing homes and long-term care facilities in the USA, infection risk is insurmountable without additional boarding options, an abundance of PPE, and caregiver and workforce support.³ A South Korean psychiatric hospital saw 101 of 103 patients contract COVID.⁴ Moreover, the risk to clinical staff is significant in inpatient psychiatric settings, particularly in parts of the USA where PPE has been in short supply.

The case illustrates a fundamental ethical dilemma of inpatient psychiatric care during the COVID pandemic: to respect patient autonomy and restore patient capacity while also mitigating infection risk to the patient and others. To navigate this dilemma, every effort must be made to engage in shared decision-making with patients about their own care. This may require enhanced psychoeducation, psychotherapeutic approaches, enlisting the aid of family and significant others, and medication (if accepted). The importance of compassionate regard for patients with serious psychiatric disorders to engage in their own care cannot be overstated; non-compulsory interventions are generally more effective than treatment over objection.

However, should shared decision-making fail, more assertive interventions may be needed. These include judicial review and action, where a judge is petitioned to order the treatment of a patient over their objection. There may, however, be several barriers to court intervention. Medical procedures—such as COVID testing—are not always considered



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To cite: Russ MJ, Sisti D, Wilner PJ. *J Med Ethics* 2020;**46**:579–580.

to be within the purview of mental health hearings about treatment over objection, and may fall under statutes related to 'emergency treatment'.⁵ It remains unclear if these statutes apply to COVID testing. Moreover, there may be considerable delays in holding these hearings, during which time the existing risk of contagion to others may persist. Delays complicate any efforts to obtain an order for treatment over objection with the hope that improvement in psychiatric symptoms would eventually lead to cooperation with infection control procedures.

If the aforementioned interventions are ineffective or impractical for the type of scenario described at the outset, are coercive or compulsory measures ever ethically appropriate? Szmukler and Appelbaum describe a hierarchy of treatment pressures ranging from persuasion to the use of compulsion.⁶ According to this model, the bar for ethical justification rises as you ascend the hierarchy of treatment pressures. Compulsory measures require the strongest justification and should be a last resort. Such measures, provided protocols are in place to ensure the safety of the patient, include manually restraining with or without sedation to obtain vital signs, a nasopharyngeal swab and other laboratory tests. These measures may also include placing patients in seclusion (locking door or enforcing room restriction), sedation or mechanical restraint, if patients are not able to adhere with isolation requirements.

Current regulations regarding the indications for seclusion and restraint require that the patient exhibit behaviours that are violent or self-destructive behaviour, emphasising the immediate physical risks to self or others. While the 'physical' properties of contagion risk can be debated, this may not be the interpretation regulatory agencies would support. Guidance in the management of patients whose refusal of testing and treatment for COVID in a psychiatric hospital places others in jeopardy is, to the best of our knowledge, not yet been developed in regulatory guidelines or accreditation standards.⁷

The last resort of forced intervention exists in a grey area of regulation. In these cases, appeals to the standard principle of respect for autonomy do little to advance a solution. In fact, such an appeal may distort the way forward by obfuscating the limits of self-determination in the context of a global pandemic where a patient lacks full capacity. Instead, drawing on the principles of beneficence and justice, we argue that notions of caring coercion and public health solidarity should apply. Under circumstances where reasonable measures have been taken to enlist the cooperation of a patient who lacks capacity, coercive interventions, understood as undesirable last resorts, are ethically appropriate.

POLICY RECOMMENDATIONS

The urgent need to protect both the individual patient and the community supersedes the presumed right of the individual patient to refuse medical interventions. Every case must be considered on its own merits, requiring careful assessment of the patient's capacity to refuse treatment while also weighing the risks associated with intervention versus non-intervention. It is almost certain that clinicians make decisions regarding coercive measures on a daily basis. These decisions are often made in 'coercive shadows'.⁸ Decisions regarding coercion should be made transparently in accord with legal and ethics guidelines.

To this end, we recommend the development of new policies and procedures to address several critical points of engagement. Clinical staff should actively and collaboratively engage the patient and their caregivers and advocates, providing psychoeducation and other psychotherapeutic interventions that aim

to persuade resistant patients to take appropriate measures to prevent COVID-19 and its spread.

To accurately determine urgency for testing, hospitals should provide daily local assessments of the risk of contagion using all available data, including history of exposure, signs and symptoms of COVID-like illness, risk of physical contact with unprotected patients and staff, and results of consultation with infection prevention and control experts.

In cases of patient refusal of COVID-19 prevention and containment, a psychiatrist should carefully assess and document the patient's capacity to refuse treatment. If a delay of testing is relatively safe, providing patients with psychiatric treatment that may enhance aspects of their capacity is appropriate. If restrictive measures must be considered as a last resort, employ methods that optimise safety for the patient and staff, and continuously re-evaluate restrictive measures while aiming to enlist patient assent and cooperation. Hospital ethics committees should serve as a key resource in further developing and implementing these recommendations.

Finally, architectural changes to the physical plant of inpatient psychiatric hospitals are now imperative. Hospitals should be designed or retrofitted to both prevent infectious disease spread but also enhance patient autonomy and freedom to move about safely. The American Psychiatric Association, the National Association of State Mental Health Program Directors, and other organisations should work with engineers, architects, and policymakers to develop safety guidelines that both protect the autonomy of individual patients while balancing the welfare of others during and after the COVID pandemic. Adequate funding to advance these recommendations must follow.

Acknowledgements The authors acknowledge Steven Sharfstein and Phyllis Solomon for their substantive feedback on an earlier version of this paper. DS acknowledges the support of the Thomas Scattergood Behavioral Health Foundation.

Contributors The three authors shared in the development of this essay. MR developed the early draft. DS and PW contributed to substantive revisions.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not required.

Provenance and peer review Not commissioned; internally peer reviewed.

Data availability statement There are no data in this work.

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