Commentary

Ethical considerations for clinicians faced with patients lacking the capacity to form reasoned judgments regarding COVID-19 tests and isolation

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Introduction

Dealing with patients suffering severe mental health problems during the Coronavirus disease 2019 (COVID-19) pandemic have raised several, complex, clinical and ethical questions (1). Such patients may need to be treated within secure facilities where many patients and staff live in close proximity, increasing the risk of disease transmission. In February 2020, in the Daenam hospital in South Korea, an infection cluster was found in the psychiatric ward, with 101/103 patients testing positive (2). In this pandemic's unprecedented circumstances, psychological pressure on medical staff has been severe (3). Clinical staff have been significantly at risk when dealing with psychiatric inpatients, especially in areas where high infection levels have led to shortfalls in personal protective equipment supply. Several strategies are required to reduce infection risks for psychiatric inpatients and their caregivers. Such strategies may include a comprehensive test program, mask-wearing, and social distancing. However, psychiatric patients would frequently not possess the capacity to make reasoned judgments regarding the refusal of testing or noncompliance with anti-infection protocols. Because of psychiatric illness, such patients may refrain from being tested or following protocols such as mask-wearing or isolation. Thus, clinicians have faced with serious ethical problems when dealing with psychiatric inpatients during this pandemic, in that they must balance the requirements of respecting patient autonomy and allowing them as much freedom of self-determination as is appropriate, against the need to protect the patient from infection and prevent them from infecting others. This commentary aimed at assisting clinicians facing with such ethical dilemmas.

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Pragmatic and ethical approaches for clinicians

To manage the aforementioned problem, engaging patients in the decision-making process must be a priority as this process relates to their care and treatment. Such engagement may require a combination of education, therapy, medication, and assistance of the patient's family and other individuals of significance. In this process, compassion is essential when managing patients with serious mental health issues and assisting them to have input into their care regime. Non-mandatory interventions are more likely to succeed than imposed interventions when the patient objects.

Nevertheless, clinicians may have to impose interventions in case of a failure in the shared decision-making process. Imposing such interventions may be done through judicial reviews, that is, with the clinicians petitioning a judge who can order that a patient be treated despite objection. However, several problems may arise with such interventions. Medical procedures such as testing for Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) may not be regarded as falling within the aegis of "treatment over objection"; they may be more likely to be considered under the "emergency treatment" protocols (4). Whether such regulations apply to testing for SARS-CoV-2 is not yet clear. Furthermore, arranging court hearings can take considerable time while the patient may remain at the risk of contracting the infection or infecting others. Such delays can cause problems in seeking an award for "treatment over objection"; and, addressing the patients' mental health symptoms can ultimately mean that they would be more likely to comply with infection control protocols.

A significant concern is whether it is ever ethically permissible to use coercion or compulsion to impose testing or treatment when other strategies have failed. Szmukler and Appelbaums detailed a hierarchy of treatment methods, beginning with persuasion and ending with compulsion (5). The authors stated that the threshold allowing the treatment to be ethically justified becomes higher as moving through this hierarchy. Compulsion must have extremely robust justification and should only be used when all other measures have failed. Compulsion measures that can be used, on the condition that safeguards are installed to ensure the patient comes to low harm, may include the use of physical restraints, either with or without sedation, for obtaining vital signs, taking swabs and other specimens for laboratory testing.

Additionally, if patients cannot comply with isolation protocols, they may need to be mechanically restrained, sedated, or secluded either by being locked in a specific room or otherwise blocked from leaving their rooms by the staff. Existing regulations related to restraint and seclusion demand that a patient must have demonstrated the propensity towards violence or self-harm that places themselves or those around them in imminent physical danger. A discussion might be

necessary regarding whether the risk of contracting or transmitting COVID-19 represents an imminent physical danger, however regulators may not regard it as such (6).

Forceful interventions, as a last resort, are not well defined within the regulations. Should forceful intervention be considered, appealing to the standard principles regarding respecting autonomy may not help much, becoming more confusing by introducing a debate on how far self-determination for patients lacking full mental capacity may be permitted amidst a global pandemic. A solution should be sought based on justice and goodwill that uses public-health solidarity and caring coercion principles. If all possible reasonable measures have been taken to persuade the incapacitated patient and failed, coercion can be morally justified, provided it is recognized as a last resort.

In case of an urgent need to protect the patient, other individuals and the wider community, the patient's right to refuse medical intervention may be overridden. Any decision about coercion must be taken transparently and should be according to all ethical and legal standards (7). Physicians and other staff should be proactive and collaborative in engaging with the patient, those who care for them, and those who support them, offering educative and therapeutic measures to persuade reluctant patients to accept necessary treatment to prevent them from contracting and spreading the virus.

To assess the urgency of testing accurately, a hospital should undertake daily assessments of contagion risks in its facility utilizing all data available including the followings: (*i*) exposure history; (*ii*) possible indications and symptoms of COVID-19; (*iii*) the chances of the patient physically contacting vulnerable patients and staff; and, (*iv*) opinions of experts in preventing and controlling infections. If a patient refuses to accept testing, isolation, or treatment for COVID-19, psychiatrists must carefully assess and document the capacity of a patient in rejecting treatments.

If delayed testing is comparatively safe, psychotherapy or medication may be appropriate to enhance patient's capacity. If coercive restriction is considered the only option, it should be applied such that the safety of both patients and staff is maintained to the maximum extent possible, and any restrictions should be regularly reevaluated to gain patients' compliance and their cooperation being continued. A hospital's ethics committee should be central to the development and implementation of the abovementioned protocol.

Finally, inpatient psychiatric facilities should be modified (and in new facilities, designed with such changes in mind) to stop infectious diseases from spreading as much as possible and allow patients to be more autonomous and move around the facility safely and as freely as possible. Hospitals should develop a set of ethics-based guidelines that allow the patients to retain their autonomy without compromising health of others, in the current pandemic and the aftermath (8). Such

interventions must be adequately funded.

Conclusion

This paper presented a path for clinicians to manage pragmatically ethical concerns regarding care for patients with severe mental health problems who refuse to take the COVID-19 tests or to comply with protocols designed to prevent infection. At the outset, the patients should be given the support required to decide themselves; however, in certain instances, decisions might be made by the clinicians based on the individuals' expressed beliefs, values, and wishes while incorporating their family's opinion on what the patients would choose if they had the capacity to decide for themselves. Clinicians can employ various treatment methods, beginning with persuasion and ending with coercion. Legal authorization might be necessary should patient right to liberty be impinged. Depending on the jurisdiction of different countries, if patients are deemed to present an immediate risk to others, including other patients and employees in the facility, clinicians might be legally empowered to detain and restrain patients for a finite period. The opinions of a hospital's ethics committee might be sought, particularly when frontline clinicians are confronted with complex ethical questions in caring for these patients. With the involvement of medical ethicist, the committee may provide professional advice by contextualizing the problems which otherwise may not be adequately addressed by the established ethical frameworks of the national health authorities.

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None

Conflict of interests

None declared.

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