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Re: COVID-19 Related Opinions of the APA Ethics Committee

APA's Ethics Committee invites members to seek advice on ethical dilemmas they face in practice. The Ethics Committee continues to receive questions related to ethical practice during the COVID-19 pandemic. Below are responses to questions we have recently received. If you have an ethics question, please submit your question to apaethics@psych.org and the APA Ethics Committee will answer it. Please do not submit questions related to the facts of any actual or pending ethics complaints.

QUESTION 1:

When we use unfamiliar technologies (e.g. telehealth technologies) to provide treatment during COVID-19, what considerations should psychiatrist be aware of to ensure disruptions of care are minimized?

ANSWER:

The availability of technology is incredibly helpful during this public health crisis as it allows psychiatrists and patients to continue treatment while apart because of physical distancing. While using these technologies, psychiatrists have an ongoing ethical responsibility to maintain patient confidentiality and proper therapeutic boundaries. Psychiatrists should inform patients that there may be limits to confidentiality given the risks inherent to the use of internet that would not necessarily exist for an in-person session and establish the expectations of the changed treatment relationship by informing patients that telehealth sessions are treatment sessions in the course of care and will be billed as such.

If a psychiatrist encounters a patient who expresses a preference to be seen in person even when physical distancing recommendations are in place, the psychiatrist may try to work with the patient to make them more comfortable with the use of technology, including by informing the patient that it is in his/her/their best interest to avoid environments (such as the psychiatrist's office building) that could increase one's chances of contracting or disseminating the infectious disease. All psychiatrists have a duty to think about the greater good given the present circumstances of the COVID-19 global pandemic. It is worth noting that reliance on technology to provide remote treatment at this time is not a matter of convenience or personal preference on the part of the psychiatrist, but instead is motivated by the responsibility to care for individual patients while also contributing to life-saving physical distancing measures to flatten the curve and minimize contagion. In these circumstances, the individual preference of the patient cannot alone justify departure from the public health responsibilities of the psychiatrist. However, where an urgent or emergent clinical situation exists, psychiatrists should, similarly, be aware that exigency may require in-person assessment and/or treatment and that principles of competent care and ethics both require that the psychiatrist provide or arrange for this care notwithstanding public health concerns, with adequate personal protections in place to decrease the risk of contracting or disseminating infection during the encounter.

QUESTION 2:

How much personal risk are psychiatrists expected to take while attending to the treatment of patients during the COVID-19 crisis and what extra duties might psychiatrists have in this environment?

ANSWER:

Historically during times of epidemic, there has been an expectation that physicians, because they are specially trained and equipped, have obligations to serve the public good, even beyond the expectations of other professions. Such obligations, however, fall along a spectrum depending upon one's skill, position, and the protections afforded the individual physician. While an individual may opt to or need to limit their actions to minimize their own personal risk and/or to protect their family, an organization (such as a healthcare facility or state health department) has an obligation to provide physicians to step in and take those risks to ensure that adequate care will be provided and to provide the personal protective equipment to the staff so that care can be safely given.

Ethical dilemmas arise when there are multiple ethical responsibilities that stand in tension with each other. During this pandemic, treating psychiatrists have competing obligations to their patients, to themselves and their families, and to the public good. Similarly, physicians have responsibility for public health efforts, but at the same time must acknowledge that the health systems in which they are asked to serve are held accountable while making decisions under conditions of uncertainty. This is why contingency plans may be required when equipment is in short supply. Organizations and governments that call upon physicians to serve in times of public health emergencies for the care of patients and promotion of public health have a reciprocal responsibility to provide protection (including Personal Protective Equipment) for physicians to allow them to provide care as safely as possible. In other words, this accountability on the part of governments and health systems for adequate safety measures is a necessary condition.

That being said, as during the current COVID-19 pandemic, actual conditions and protections may deviate from the ideal during times of public health emergencies. These are very difficult issues being faced at a very difficult time for humanity. When determining the appropriate resolution of professional ethical dilemmas, it is important to maintain humility – while psychiatrists can and should think through how to balance competing responsibilities in any individual case, they also must recognize that often the answer is not clear and it will always depend on the circumstances of each individual case. Psychiatrists should be aware of the both the risks of service and of recusal from service in light of medicine's responsibilities to the public good as a healing profession. There are no simple answers and psychiatrists are encouraged to seek consultation with colleagues and ethics resources to navigate these challenging times. Please see response to Question 4 regarding practice outside of your normal area of expertise.

QUESTION 3:

I work at a state inpatient hospital where patients are 4 per room and all are elderly. The hospital has adopted an isolation policy for incoming patients due to COVID-19 but has otherwise not implemented physical distancing measures (for example there is still communal dining). I have complained to

management, but I remain concerned that if one patient infected with COVID-19 comes into the facility it will wipe out the entire unit. What are my ethical obligations?

ANSWER:

This question starkly illustrates that providing necessary medical care in conditions of crisis and scarcity is an incredible challenge. The options available to the individual psychiatrist in the circumstances presented are limited. Certainly, within a system of care, the individual has an ongoing responsibility to advocate for change and ensure adequate care for patients. *See, e.g. APA Commentary on Ethics in Practice, Topic 3.4.1* (“In increasingly complex systems of care, treating psychiatrists will encounter situations in which the primacy of individual patient care competes with other compelling interests and obligations. Psychiatrists in any system of care, whether or not they are providing clinical care to individual patients, maintain responsibility to patient interests and commitment to promoting organizational ethics supportive of individual patient care and care of patients more generally”). The psychiatrist, therefore, should continue to advocate to management and those with the ability to change procedures to make appropriate changes in accordance with public health directives for the COVID-19 pandemic. In addition, when the psychiatrist can implement steps that would increase physical distancing or otherwise follow the recommendations of public health officials, he/she/they should do so. At the same time, the option of refusing to provide care at this facility or pursuing the closure of this type of unit at a state hospital is not a result that would likely lead to improvement of the psychiatric care of individual patients (as no alternative exists) or the public health overall. Given this extreme scenario, the individual psychiatrist must determine what steps can realistically be taken that improve compliance with public health guidance while maintaining the availability of needed medical care.

In addition to strongly advocating for patients, the psychiatrist should also engage in creative measures to protect patients however possible. For example, in situations where physical distancing is not feasible, the psychiatrist may be able to implement other available measures that contribute to primary prevention of infection and early detection of cases such as: (i) quarantining new arrivals to the unit for 14 days; (ii) providing masks for all patients in community areas; (iii) monitoring vital signs (including temperature and respiratory symptoms) for all patients; (iv) testing of all new admittees to the unit when possible; and/or promptly quarantining patients with symptoms and isolating confirmed contacts. Also, there should be strict screening of staff using both a questionnaire and temperature check to prevent staff from introducing infection to the unit.

Psychiatrists may experience personal moral injury in response to acts that violate their personal moral code and/ or professional norms. While it may be useful to think about the larger context of the public mission and the very stark context humanity finds itself in now that is so different from our normal way of life, psychiatrists should also be aware of resources for self-care, emotional, and spiritual support.

QUESTION 4:

In a public health emergency like COVID-19, is it ethical to practice outside my normal area of competence?

ANSWER:

Several competing interests are brought up by this question: (1) the responsibility of physicians as a profession to serve the public good and community at large during a public health crisis; (2) the responsibility to practice competently and not unnecessarily expose patients to risk; and (3) the possibility of personal liability if a physician practices outside his/her/their usual scope or environment when harms as well as benefits may occur.

Each individual psychiatrist, when confronted with the possibility of practicing outside of their usual practice area, must think first about what he/she/they are sufficiently competent to do and whether he/she/they can become competent to do more with supervision and training.

Psychiatrists are trained as physicians. One's competence to step into a general medical unit may depend upon the time elapsed since medical school and internship, the degree to which the physician has kept current in general medicine through education and practice experience, the ability to be part of a team with other physicians and to hone skills that have not been recently used, and the training and supervision available to enable you to step in in a manner that will be helpful outside of your area of expertise. Ultimately, individual physicians remain responsible to resist if they are asked to practice medicine in a manner for which they lack competence, have no ability to become competent quickly, and therefore could not provide adequate care. The physician principle to avoid harm always applies. Individual psychiatrists must not allow themselves to be pressed into actions that, because of the physician's lack of competence, are reasonably likely to cause harm to patients. Appropriate training, supervision, and provision of appropriate Personal Protective Equipment by health systems and governments are important aspects of expecting and allowing psychiatrists and other physicians to competently practice outside of their usual areas of practice.

Psychiatrists who do not believe they can competently assist outside of psychiatry (e.g. staffing medical respiratory clinics or operating ventilators) may nonetheless contribute to the pandemic response in other ways. For example, psychiatrists may provide telepsychiatry to front-line workers and take on some of the patient load of psychiatrists who have stepped into other medical roles. They may also contribute as citizens (for example, by making donations of blood, or donating food to hospital workers or communities particularly impacted by the virus).

States have approached the issue of potential personal medical liability differently. APA is advocating for the passage or expansion of Good Samaritan laws and liability exceptions during the COVID-19 crisis for physicians who in good faith provide care during the epidemic that is outside their established competence or normal area of practice.

[APA's statements and guidance on the deployment of psychiatrists during this epidemic](#) addresses many of these issues and is consistent with these ethical guidelines.

ADDED MAY 29, 2020:

QUESTION 5:

I practice adult and geriatric psychiatry. I admit my own outpatients to a locked psychiatric unit in a general hospital and treat them when they are inpatient. The hospital does not test patients for Covid-19 before admission unless they are "symptomatic". They say that they do not have enough rapid tests and that the CDC does not require such testing. I believe that it is unsafe medically to admit patients to a locked unit, with shared rooms and dining room without Covid-19 testing. Some of the patients come from group living situations, others are homeless, and many are so disorganized that they cannot present coherent medical histories or social histories. As we know, many people are asymptomatic yet contagious. At this time I do not believe it is safe for me to admit patients, particularly my geriatric patients. Does the APA have a comment or statement about the issue of Covid-19 testing prior to psychiatric admission?

ANSWER:

APA does not at this time have a policy statement regarding COVID-19 testing prior to psychiatric admission. Members of the APA Ethics Committee are not yet aware of a nationwide consensus that testing should be performed on every new admission although there are some indications that the recommended guidance of public health officials may be moving in that direction. In an ideal scenario, all new admissions should be tested, but the clinicians and institutions need to also be aware of the limitations of testing.

In addition to the fact that there are not enough tests currently available nationally to test all patients, symptomatic or asymptomatic, testing is only useful when it yields a positive result. Unfortunately, a negative result only tells you the individual is negative at that particular point in time; such an individual could become positive the very next day, and therein lies the risk. The high rate of false negative results, and the decreased ability of the tests to detect the virus at certain periods of an asymptomatic presentation makes it hard to safely conclude that a negative test is in fact negative. In order to avoid a false sense of safety, it is also appropriate to maintain distancing and hygiene measures for all patients admitted for 14 days (e.g. physical distance, masking, hand-washing and sanitizing stations, extra precautions at mealtimes), as these practices would give a better window of safety than a potentially false negative test result. This would also protect others from an asymptomatic COVID-19 positive patient.

In conclusion, if tests were readily available, it would be important to test all admissions while being mindful that this is only one piece of the interventions needed for safety, especially for negative results. In addition to testing data, clinicians and hospitals should be mindful of and use the clinical criteria for suspicious cases by assessing individual and epidemiologic risk (see, e.g. <https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html>).

If an individual psychiatrist believes that the practice of the hospital to which he/she/they admits patients makes it not safe to admit patients, it is possible that he/she/they should not do so. Such a psychiatrist should advocate for changes in the relevant procedures to make admission safer, including

increased testing and isolation/quarantine of new patients. The individual psychiatrist remains responsible for balancing the risk and benefit of admission for each patient while continuing to advocate for facilities to adopt and follow the best realistic and feasible practices.

QUESTION 6:

Would appreciate your consideration of these questions which have arisen at our public sector inpatient psychiatric facility: It was recently decided to have all admissions given nasopharyngeal swab screening for COVID-19. For patients who were admitted voluntarily prior to this decision, is it ethical to compel them to submit to testing as a condition for continued hospitalization, even if asymptomatic? For patients seeking voluntary admission, and meeting medical necessity criteria for admission (i.e., expressing suicidal ideation, homicidal ideation, or appearing unable to care for themselves), is it ethical to deny voluntary admission based on their refusal to voluntarily submit to testing? (For example, would a psychiatrist be ethically justified to admit an otherwise voluntary patient involuntarily so as to force testing and continue with inpatient treatment thereafter.)

ANSWER:

While it is not recommended to force an individual patient, competent or not, to undergo nasopharyngeal swab for COVID-19 test, clinical administrators of the unit do have an obligation to keep the other patients safe. They can meet this responsibility by maintaining the refusing patient in quarantine for 14 days, the time it would take for any individual exposed to a suspected or confirmed COVID-19 positive person to develop and exhibit symptoms of the infection, if the resources to do so are available. After 14 days without symptoms, the refusing patient would be deemed COVID-19 negative.

It may be unethical to deny admission to a patient meeting medical necessity for psychiatric admission (voluntary or involuntary) based on their refusal to submit to testing for COVID-19, although in the setting of contagion and a global pandemic, institutions have broad latitude to protect the public health and physicians have responsibilities to both individual patients and to the greater public good that must be balanced. If there are other interventions available to the clinicians to protect other patients on the unit from the newly admitted patient with unclear COVID status, while protecting the patient from him/herself, accommodations may be made.

It is important to note that testing for COVID-19 is a medical and not a psychiatric intervention, and it is not based the legal status of a patient's admission, voluntary or involuntary. A competent patient has a right to refuse treatment or testing of any kind in ordinary circumstances, even if they were admitted to the hospital involuntarily. For a patient without the capacity for informed consent the patient's representative may have the authority to request testing against the patient's wishes. It would be best, however, to work hard to avoid this situation as much as possible, for example by quarantining the patient, forming an alliance with them and trying to obtain the testing through gaining the patient's trust. If that proves not possible, the patient's quarantine could be continued for 14 days. Finally, isolating a patient is not without risk to staff and without cost. For example, the added PPE use at a time of shortage and the need for extra personnel may not be reasonable or responsible. Ultimately, the final consideration will be a balancing between the individual patient and risk to other patients in

the facility and the greater public health situation given the current global pandemic.

It is important to be aware every new admission is a risk to older confined patients with co-morbid conditions, under some circumstances there could be an argument for limiting or pausing admission to a particular hospital and/or ethical imperative for at least a strong effort to persuade or induce unwilling patients, if not mandate testing in high risk settings. Hospitals have the prerogative to set their admission standards and requirements for both voluntary and involuntary admission (but not to violate the law in setting them). Infection control and management in the setting of the pandemic is a legitimate and paramount consideration for any facility, public or private.

Finally, psychiatrists may wish to examine the laws in their jurisdictions regarding quarantine and other public health measures in an epidemic or pandemic regarding who, if anyone, may have the authority to mandate testing or isolation. As a public health issue, the Commissioner for Public Health, rather than Mental Health, may be the legal authority regarding testing and other contagion-related guidance or regulations.

QUESTION 7:

Does APA have a position on reopening offices given that telehealth remains an option? What happens if a patient gets sick and it is traced to your office? How do you participate in contact tracing and maintain confidentiality?

ANSWER:

While APA does not have an official policy or position statement regarding the use of telehealth during early phases of reopening following COVID-19 closures, it expressly recognizes that, for patients who have responded to telehealth, the safest way to continue providing treatment in early phases of reopening is through telehealth even as some physical clinical locations begin to reopen. As noted in previous answers, a psychiatrist may try to work with patients to increase their comfort with and benefit from telemedicine technology. When a psychiatrist determines that in-person assessment or treatment is necessary to provide competent care for particular patients, the psychiatrist must take appropriate precautions to protect themselves, their staff, and patients from risk of COVID-19 exposure during patient visits. Psychiatrists who will provide in-person treatment should consult, among other things, guidance provided by the CDC and federal, state, and local authorities as well as all recommended infection control practices set forth therein. As physicians, psychiatrists have a duty to promote public health and take steps to protect themselves and others from exposure during the present circumstances of the COVID-19 global pandemic.

Psychiatrists should request that any patient who has received in-person treatment contact the psychiatrist if the patient or any member of their household tests positive or becomes ill with COVID-19, regardless of the presence and/ or severity of symptoms. In addition, as a reminder, psychiatrists are always responsible for informing patients that there may be limits on the confidentiality of a treatment session. Specifically, during the present COVID-19 global pandemic, psychiatrists should expressly inform all patients who require in-person treatment that the psychiatrist may need to reveal confidential information, including the identity of the patient, in light of the psychiatrist's public health

obligations. Advancement of public health interests is a long-recognized exception to the obligation of medical confidentiality. The responsibility to report exposure to public health authorities for the purpose of allowing contact monitoring, isolation, treatment, mitigation and prevention efforts to slow the spread of illness is an essential obligation of psychiatrists. Releasing confidential health information to public health authorities is expressly permitted under the HIPAA Privacy Rule (*see* 45 CFR 164.512(b)) and allowed under the APA's *Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry* when required under applicable law (*see* Section 4). Finally, psychiatrists should also inform patients that patients may be required to disclose their in-person contact with a psychiatrist for public health reasons, e.g., in jurisdictions engaged in contact tracing to contain the spread of COVID-19.

When a psychiatrist, a member of the psychiatrist's staff, a patient, or a member of any of those persons' households is ill with or tests positive for COVID-19, the psychiatrist should make a mandated report to the appropriate public health authority in their jurisdiction, which may include obligations to provide otherwise confidential information for the purpose of contact tracing for exposure to SARS-CoV2, as above. Any time that a psychiatrist reveals confidential patient information, even when legally mandated, the psychiatrist should be as protective of patients' privacy as possible including by sharing the minimum necessary information and by taking care to avoid subjecting patients to surprise contact from public health officials. It would, for example, be sound practice for the psychiatrist or a member of the psychiatrist's staff to contact patients directly to inform them of the potential exposure and prepare them for the possibility of being contacted by public health authorities.

QUESTION 8:

I have questions about the ethics surrounding discharging covid+ involuntary patients on inpatient psych. Can we quarantine involuntary patients on the unit while they wait for placement? If they are psychiatrically ready for discharge and ask to leave, can we discharge them to the street if shelters will not accept them (due to covid status)? Can we discharge a patient home if we have concern that they will infect their primary caretaker, could this be a danger to others and even self?

ANSWER:

Involuntary patients can indeed be quarantined in a public health emergency, although regulations should be tailored to distinguish seclusion for behavioral reasons from infectious ones. Best practices for Departments of Health include such practices. This is based in communitarian principles like self- (and community) protection or preservation.

Discharge decisions complicated by infectious concerns can adopt the risk-benefit approaches often used for families who assume responsibility for their family members with mental illness. Safety of the caregiver is an important consideration in such cases and is fueled by principles like fidelity, non-maleficence, and proper distribution of scarce resources (fairness).

Public sector agencies rarely discharge to shelters because their patients are vulnerable and need significant resources to remain healthy, so discharging an infectious patient to the streets poses both a safety risk to the patient and the community at the same time. It also violates the public sector's safety

net mission. If a competent, voluntary patients insists on a dangerous discharge, public health principles (perhaps invoking a Commissioner's public health order) may be necessary.