COVID-19 and the Duty to Protect from Communicable Diseases

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At any point in time, there are multiple communicable diseases present around the globe. The diseases can be categorized based on their pattern of spread.[1] The descriptions are based on expected numbers of cases at any point, coupled with the geographic spread of the condition (Table 1). A disease can move up and down the progression of descriptions based on changes to the features.

There have been several recorded pandemics in recent history. The most recent respiratory disease pandemic was the 2009-2010 spread of the H1N1 virus, also commonly referred to as the "swine flu." The World Health Organization (WHO) reported an official worldwide death toll of approximately 20,000 caused by the H1N1 virus.[2] Simonsen and colleagues (2013) more recently reported that the total pandemic mortality burden could be 10 times the number of laboratory-confirmed deaths, based on their applied model.[3] Another H1N1 virus, commonly referred to as the "Spanish flu," spread across the globe in 1918-1920 and killed an estimated 50 million individuals.[4] That pandemic prompted considerable worldwide fears, with related social impact and changes to behavior.

The WHO officially declared the coronavirus disease 2019 (COVID-19) a pandemic on March 11, 2020.[5] International travel is much more common and rapid than it was in 1918-1920, which contributed to the rapid global spread of COVID-19. At the time of writing, there were more than 638,000 confirmed COVID-19 cases and more than 30,000 deaths worldwide, with the numbers expected to increase over the following weeks.[6] Another unique challenge has been the rapid proliferation of information (and misinformation) through multiple avenues, including 24-hour news outlets and social media platforms. On the positive side, one advantage of the rapid dissemination of information has been that governments and individuals can quickly learn from experiences elsewhere in the world when designing policies and testing potential treatments.

COVID-19 appears to be more transmissible than influenza, with each sick individual infecting an estimated 2.5 others.[7] Containment efforts therefore have focused on several non-pharmaceutical interventions, such as hygiene and limiting interpersonal contacts. The term "social distancing" quickly has become part of the lexicon.[7]

Early containment efforts have led to mixed results in the United States, with considerable regional and individual variations. Images of youths gathered in Florida for spring break in March, despite social distancing recommendations, sparked upset.[8] Individuals posted videos on social media involving deliberately coughing or sneezing on groceries.[9] Extremist factions encouraged infected followers to target groups using COVID-19 as a form of small-scale biological terrorism.[10]

As containment efforts were implemented, global medical systems prepared for an onslaught of COVID-19 cases. Every medical field had to rapidly implement or adjust policies to ensure adequate management and treatment of affected individuals. With the rapid spread of the disease and the absence of an approved COVID-19 specific treatment,[11]

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Table 1 Disease Spread Patterns (adapted from Grennan[1])

Term	Spread Pattern
Endemic	Condition present at a steady rate among a population
Outbreak	Condition occurring above endemic levels
Epidemic	Outbreak that has spread to larger geographical area
Pandemic	Condition that has spread across the globe

though, unprecedented ethics challenges arose. Some overwhelmed medical systems unimaginably faced the task of having to consider criteria for selecting which individuals could receive limited life-saving treatments, such as ventilators.[12]

Not unlike other medical specialties, psychiatry also has had to adjust. In addition to the logistical conundrums of providing clinical care despite social distancing, psychiatrists also have faced a set of unique dilemmas. Inpatient psychiatry units routinely house patients who are being hospitalized involuntarily. Remaining on a locked psychiatric unit with other patients could pose additional risks of COVID-19 exposure to civilly committed individuals who are unable to leave on their own accord. As an example, after a couple of patients in the psychiatric ward of Daenam Hospital contracted COVID-19, South Korean health officials and the hospital administrators elected to lock down the ward. This led to 101 patients (almost the entire ward's population) developing the disease, with seven subsequently dying.[13]

Other patients with active psychiatric symptoms could have COVID-19 symptoms or exposures prompting recommended quarantine; however, they might have an impaired ability to follow social distancing recommendations due to their active psychiatric symptoms limiting their understanding of the recommendations. Could this possibility alone warrant sufficient "danger to others" consideration to prompt civil commitment? If so, and if those patients are symptomatic, where in the hospital should they be treated? What if they pose an elopement risk? Many of these questions do not have clear answers. With the COVID-19 pandemic raging across the globe, it is imperative that we revisit and examine the duties psychiatrists need to consider when attempting to protect third parties from communicable diseases.

Ethics Perspectives

The American Medical Association's (AMA) Code of Medical Ethics includes the Principles of Medical Ethics and the Council on Ethical and Judicial Affairs' Opinions.[14] The Principles highlight the professional ethics by which physicians are expected to abide. Principle IV specifies that physicians should "safeguard patient confidences and privacy within the constraints of the law."[15] Principle VII states, "A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health."[15]

Code of Medical Ethics Opinion 8.4 expands on this directive and states that in the case of an epidemic, physicians should "support mandatory quarantine and isolation when a patient fails to adhere voluntarily," and "inform patients about and comply with mandatory public health reporting requirements."[16] Furthermore, the American Psychiatric Association (APA) specified in its annotations to section 4 of the Principles that a psychiatrist "may disclose only that information which is relevant to a given situation" (Ref. 17, p 6) and "may reveal confidential information" when "the risk of danger is deemed to be significant" (Ref. 17, p 7).

Traditionally, the APA's ethics annotations have been interpreted as addressing the duty to disclose information pertaining to a patient's "significant" risk to intentionally harm a specific third party. Psychiatrists, as physicians, should comply with the AMA's Principles and practice within the confines of the law;[15] however, amid the rapidly expanding COVID-19 pandemic, psychiatrists are facing novel scenarios with unclear legal guidance.

Legal Perspectives

States' police powers include the authority to protect the health and welfare of the general public through enacting appropriate legislation. Accordingly, states can restrict individual privacy and liberties within constitutional limits.[18] In *Whalen v. Roe*[19] (1977), the Supreme Court of the United States unanimously upheld the right for states to obtain and store patients' private health information. The Court noted:

> Disclosures of private medical information to doctors, to hospital personnel, to insurance companies, and to public health agencies are often an essential part of modern medical practice even when the disclosure may reflect unfavorably on the character of the patient. Requiring such disclosures to representatives of the State having responsibility for the health of the community, does not

> automatically amount to an impermissible invasion of privacy (Ref. 19, p 602).

When it comes to mandatory reporting of communicable diseases, laws have differed by state. In a recent survey of the relevant legislation during the H1N1 pandemic, Danila *et al.* found that close to 90 percent of U.S. states had legislation mandating reporting of new and emerging suspected or confirmed diseases; however, about a third of U.S. states did not require immediate reporting of new diseases.[20] Only 80 percent of those jurisdictions considered physicians to be mandatory reporters.[20] For example, California mandates many categories of individuals to disclose relevant information pertaining to a person with a communicable disease to the local health authorities. California's § 120250 of its Health and Safety Code states the following:

> All physicians, nurses, clergymen, attendants, owners, proprietors, managers, employees, and persons living with or visiting any sick person in any hotel, lodging house, house, building, office, structure, or other place where any person is ill of any infectious, contagious, or communicable disease, shall promptly report that fact to the health officer, together with the name of the person, if known, the place where he or she is confined, and the nature of the disease, if known.[21]

California updated its list of reportable diseases in March 2020 to include COVID-19, requiring health care providers to "report immediately by telephone" the case to the local health officer (Ref. 22, p 1). Providers are required to fill out a Confidential Morbidity Report which includes the patient's private health information and submit it to local authorities. Failure to report is a misdemeanor under California law and a citable offense under the Medical Board of California Citation and Fine Program.[22]

Despite the widespread enactment of laws requiring reporting of infectious diseases, compliance by health care providers is inconsistent. Typical reasons include a lack of general knowledge about the mandate and its process, an unwillingness to break doctor-patient confidentiality, and the lack of a substantial penalty for failure to report.[23] Penalties for not reporting a communicable disease to local health authorities include license revocation and malpractice litigation; however, they are rarely enforced at the state level.[24] All physicians, including psychiatrists, are concerned about liability claims arising from breaking confidentiality to disclose patients' private health information to public health authorities. Those concerns are likely unfounded, though, as local and state health authorities prohibit public disclosure of individual data and are equally protective of it.[19,25]

Furthermore, failure to comply with disclosure laws can lead to tort liability. In *Derrick v. Ontario Community Hospital*[26] (1975), the plaintiffs James Derrick *et al.* alleged that the hospital was negligent in not reporting a patient's communicable disease; the plaintiffs claimed that had the hospital reported it, the local health officer would have taken appropriate measures to prevent the plaintiffs from acquiring the disease through contagion. The Court of Appeals of California, Fourth Appellate District, Division Two, held that the hospital had a duty to report the communicable disease to health authorities. The court also held that the hospital could be found liable if the plaintiffs prove that not reporting the disease was the proximal cause of the plaintiffs' injuries.[26]

Although some might argue that psychiatrists are less likely to diagnose patients with COVID-19 in their clinical encounters, it is important to emphasize the crucial role all health care providers should play in curbing this pandemic. Psychiatrists might have patients who develop symptoms of COVID-19 on the inpatient wards; they will be responsible for implementing the necessary protocols to care for the affected patients, as well as the potentially exposed patients, families, and unit staff.[27]

Other scenarios might be more challenging. Patients presenting to psychiatric clinics might have been in contact with confirmed cases or might present with symptoms suggestive of COVID-19 without taking the required protective measures. Psychiatrists facing such cases might be uncertain as to whether they are required by law to report such patients for fear of being found liable for breaking confidentiality or losing the patients' trust. They are urged to remain familiar with their jurisdiction's established parameters.

In addition to the ethics and legal predicaments regarding mandatory reporting to local health authorities, psychiatrists also face a dilemma regarding whether to inform third parties at risk of their patients' COVID-19 status. States have differed in imposing on physicians a duty to warn third parties with regards to communicable diseases. In *Doe v. Cochran*[28] (2019), a divided Connecticut Supreme Court held that a physician had a duty of care to his patient's exclusive partner (the plaintiff) and was

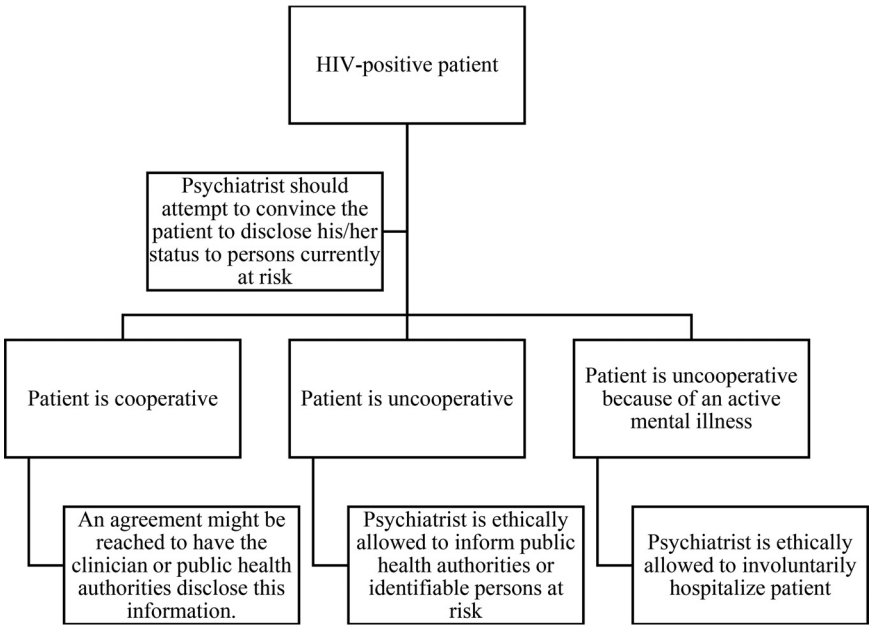

Figure 1. Algorithm for psychiatrists based on the APA's position statement on HIV/AIDS and confidentiality, disclosure, and protection of others.[32]

negligent in misreporting the results of his patient's sexually transmitted disease (STD) test; misreporting the test results led to the plaintiff contracting the STD. Furthermore, the court argued that imposing a third-party duty was justified and would not affect the "sanctity" of the physician-patient relationship given the broader public health concerns.[28]

The AMA filed an amicus brief supporting the defendant.[29] It argued that imposing a duty of care to unidentified third parties would negatively affect patient care by threatening doctor-patient confidentiality. Interestingly, the AMA referred to the *Tarasoff*[30] holding as a "key benchmark when deciding when to expand a physician's duty" (Ref. 29, p 11). It further stated, "Exceptions like *Tarasoff* are the most ethically sound, as the third-party is readily identifiable, there is an emergency risk of serious physical bodily harm or death, and a special relationship exists" (Ref. 29, p 11). This raises the question of whether *Tarasoff* statutes apply when a patient with a confirmed or suspected COVID-19 diagnosis does not follow public health recommendations.

Our current knowledge of COVID-19 leads us to believe that it is a highly contagious and potentially deadly illness. Even asymptomatic carriers can be contagious.[31] While we are not aware of any current peer-reviewed studies addressing individual adherence to public health recommendations, there are abundant news stories about peoples' lack of adherence to recommendations.[9] Health care workers, including psychiatrists, obviously are not expected to police the public and enforce regulations. Yet, they are urged "to participate in activities contributing to the improvement of the community and the betterment of public health" (Ref. 15, Principle VII). Reporting a communicable disease and warning affected third parties could fall under that category.

The HIV Example

In 2009, the APA published a position statement addressing the matter of confidentiality and protection of third parties with regards to patients with suspected or confirmed HIV/AIDS.[32] The APA clarifies that if the psychiatrist "knows, or has reason to suspect, or intends to inquire about the patient's HIV-status or risk behaviors,"[32] the clinician should disclose the limits of confidentiality to the patient *a priori*. In case the patient is indeed HIV-positive and is engaging in behaviors endangering others, the APA recommends using a stepwise approach, as shown in Figure 1.[32]

The APA's policy statement is a reasonable algorithm for clinicians to follow but is not legally binding. As noted above, most states require mandatory reporting of HIV diagnoses to public health authorities, but only a few states have enacted

statutes expressly allowing physicians to disclose the HIV status of a patient to a "person at risk"[33] (Indiana) or a "spouse"[34] (North Carolina) under strict conditions.

Conclusions

Dealing with the COVID-19 pandemic requires a rapid and streamlined reporting process in which all health care workers, including psychiatrists, can actively participate. Legislation specific to emerging diseases should perhaps be enacted to strengthen public health surveillance and rapidly address epidemics or pandemics. Until such statutes are enacted, psychiatrists will need to exercise their clinical judgment and balance their professional duties to their patients and to their communities, consulting legal experts if questions arise.

Psychiatrists can discharge their duty through immediately reporting cases of COVID-19 to their local health officers who, in turn, should oversee taking the appropriate measures in line with state recommendations. Although psychiatrists have a duty to warn at-risk third parties in compliance with *Tarasoff*-type statutes, such statutes are not ubiquitous across the United States: they are mandatory in 26 states and permissive in 17.[35] It is unclear, however, if such statutes protect against liability for disclosing a patient's COVID-19 diagnosis to third parties.

Health care workers also can be potentially liable in litigation alleging that a health care-acquired infection was caused by medical negligence.[36] Psychiatrists, therefore, should be mindful of their own health status and should follow the CDC's directives to health care workers regarding precautions and isolation requirements in case of infection.[37]

Telemental health (TMH) seems to be a reasonable alternative to provide psychiatric consultations to patients. The APA emphasized the role of TMH in its practice guidance for COVID-19.[38] Additionally, the Department of Health and Human Services and the Centers for Medicare and Medicaid Services alleviated some reimbursement and HIPAA restrictions to facilitate access to and delivery of mental health services during the pandemic.[38]

The COVID-19 pandemic is a revolution. In this era of globalization and extreme connectedness, it is laying bare the risks associated with traditional and commonplace behaviors in real time. It is challenging humans across the world to adapt and innovate to survive. Videoconferencing is the new business norm.[39] Handshakes have been replaced with elbow bumps.[40] Religious leaders around the world have canceled services and modified practices accordingly.[41] Psychiatrists too should assume their re-sponsibilities in this revolution by analyzing behaviors in times of crises, identifying opportunities for change, and actively working on furthering such changes for the "betterment of public health" (Ref. 15, Principle VII). It is important that psychiatrists remain focused on those roles during these challenging times.

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