Pragmatic Approaches to COVID-19 Related Ethics Dilemmas for Psychiatrists

William Connor Darby, MD, Michael MacIntyre, MD, and Robert Weinstock, MD

Psychiatrists face complex ethics dilemmas in the COVID-19 pandemic era when assessing dangerousness in patients or forensic evaluees who threaten to purposely infect others or spread the virus. Understanding local public health and medical quarantine laws for their jurisdictions can help guide treating psychiatrists in how to handle some of these situations; however, challenges occur when what is ethically best conflicts with the action that will confer the greatest protection against legal liability. Additionally, the calculus of weighing competing ethics considerations changes based on how relevant it is to the duties of a particular role (e.g., treatment, forensic, research, managed care, etc.) as well as the contextual factors of the situation. We present dialectical principlism as a framework to help psychiatrists resolve such ethics dilemmas related to the COVID-19 and future pandemics, illustrating how it can be applied in different roles (i.e., treatment versus forensic) and situations (i.e., when it is clear the danger of viral transmission is secondary to a delusion versus a delusion-like belief) to come to the best outcome that balances patient welfare, legal considerations, and societal safety. Occasionally, the most ethical action may entail small liability risks.

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With the rapid spread of the COVID-19 pandemic, entire cities, counties, and countries have been quarantined and people ordered to stay at home for varying periods of time.[1] Increased global travel and urbanization will likely lead to future pandemics of increased frequency and intensity.[2]

Complicated public health situations arise with highly infectious diseases. Policymakers must decide when a disease is sufficiently dangerous to justify restricting some individual liberty rights to protect others. While some policies may not go far enough to prioritize public health and protect people, courts may play an important role determining whether legislative actions go too far. Vulnerable groups (such as ethnic minority populations, those with serious mental illness [SMI], or other traditionally disenfranchised persons) are more likely to be disproportionately affected by pandemics because of structural racism and other barriers to health care; thus, special attention and efforts are necessary to promote marginalized populations' health in pandemics as well as prevent unfair liberty restrictions against them when implementing paternalistic policies. Additionally, policymakers often distort the causal relationship between mental illness and public danger and create policies that yield little to no real societal protection while unfairly limiting liberty interests for persons with SMI.[3,4]

Psychiatrists face the familiar quagmire of determining if a nexus exists between a person's mental illness and societal danger, but now specific to spreading COVID-19. Uncertainty regarding the contagion risk conferred when persons with mental illness violate public policies intended to reduce COVID-19 transmission further complicate psychiatrists' task of determining if sufficient danger exists to warrant involuntary commitment or other liberty restrictions.

Ghossoub and Newman discuss the ethics, legal, and clinical considerations for breaching confidentiality

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Dr. Darby is Director, UCLA Forensic Psychiatry Fellowship Program, Health Sciences Clinical Assistant Professor, Dr. MacIntyre is Health Sciences Clinical Instructor, and Dr. Weinstock is Health Sciences Clinical Professor of Psychiatry, Department of Psychiatry and Biobehavioral Sciences at the David Geffen School of Medicine, University of California, Los Angeles, CA. Address correspondence to: William Connor Darby, MD. E-mail: wdarby@mednet.ucla.edu.

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to inform at-risk third parties of their patients' COVID-19 status.[5] Gold and colleagues underscore how the public's overblown fears of persons with SMI spreading COVID-19 infections could, in certain scenarios, lead to unfair violations of patient autonomy via the misapplication of the involuntary commitment process.[6] They contend involuntary hospitalization should be reserved only for scenarios where the danger related to contracting or spreading COVID-19 is secondary to acute exacerbations of psychiatric disorders likely to respond to treatment in psychiatric hospitalization settings (i.e., promoting the beneficence principle). They assert that the stable contagion risk related to chronic limitations of a SMI or substance use disorder are better addressed by medical quarantine laws. Sorrentino, *et al.* raise additional ethics concerns related to the nonmaleficence principle; they illustrate how the risk of contracting COVID-19 during hospitalization may outweigh any potential benefits.[7] They also raise autonomy concerns regarding situations where it is ambiguous whether the danger from unsafe behaviors derives from patients' unsupported, false personal opinions about COVID-19 rather than from their mental illness.

Psychiatrists practicing in a variety of roles (e.g., treatment and forensic) and settings (e.g., outpatient, inpatient, and correctional) face serious dilemmas related to how best to prioritize competing ethics principles when balancing individual and public interests. The stakes for certain forensic evaluations are even greater given that incarceration carries an increased risk of contracting the COVID-19 illness, spreading the disease, and death.[8] The specific role for psychiatrists (e.g., treatment versus forensic) shapes how conflicting ethics considerations are weighed and balanced. For example, when evaluating persons communicating plans to infect others with COVID-19, treating psychiatrists may weigh public safety concerns differently than they would if they were in the forensic role evaluating criminal defendants. Moreover, psychiatrists in these different roles may face legal constraints that influence what they can do. Psychiatrists face challenges in determining whether a person's decision to ignore various infection control laws reflect chronic, irrational belief systems that are thought to be untreatable (e.g., believing the dangers of COVID-19 are fabricated by the media for political reasons) or a psychotic process (e.g., experiencing persecutory delusions that a cabal conspiracy is using the media to lie about COVID-19 dangers to control and torture them).

Psychiatrists face legal constraints related to the pandemic that may sometimes conflict with professional ethics obligations. Although it is rarely advisable to violate laws even when they conflict with ethics duties, understanding legal regulations can help inform the psychiatrist how best to navigate and resolve these dilemmas. Many laws and policies have sufficient ambiguity to allow for differing interpretations depending on context and role. We first review the relevant statutes and case law related to communicable infections and diseases, such as tuberculosis, relevant to the COVID-pandemic era. Next, we present dialectical principlism as an approach that balances competing ethics principles and considerations based on the role of the psychiatrist and context of the situation.[9] This method is most helpful in complex ethics situations when duties conflict rather than ordinary, straightforward situations in which simply following an ethics guideline will be sufficient. Finally, we illustrate how psychiatrists can apply dialectical principlism to hypothetical COVID-related dilemmas and how the role of the psychiatrist and context of the situation affect ethics-based decision-making.

Legal Principles regarding Contagion

Officials mitigate the spread of pandemics through public health laws. These legal processes (constitutional, statutory, regulatory, or judicial) are designed to assure public health.[10] Protecting public health requires broad powers for officials, in the name of public safety and beneficence. "Police powers" allow the state to enact and enforce laws promoting the general welfare of its citizens. This principle often justifies enforcing civil self-protection rules, including involuntary inspection, isolation, and quarantine of persons to prevent disease spread.[11] Ninety years ago, the California Supreme Court stated "the preservation of the public health is universally conceded to be one of the duties devolving upon the state as a sovereignty, and whatever reasonably tends to preserve the public health is a subject upon which the legislatures, within its police power, may take action" (Ref. 12, p 354). More recently, the Superior Court of New Jersey described the detention of a man refusing self-isolation or treatment for tuberculosis as "an archetypical expression of police power" (Ref. 13, p 191).

Laws have been passed and approved by courts allowing for surveillance, mandatory reporting, testing and screening, mandatory vaccination, direct observed therapy, and detention, quarantine, and isolation.[1,14–18] Rights-based limits to police powers are inherent in constitutional principles, including individual rights to freedom of expression, freedom of religion, right to bodily integrity, expectation of health information privacy, equal protection, due process, and freedom from unlawful government.[10] Though many public health policies infringe on these rights, they are often acceptable under principles of beneficence and public safety.

No public health official has unlimited authority, with courts ensuring governments follow due process. In public health, this is often satisfied by a "rational basis test," requiring that government interventions be plausible, but not necessarily persuasive.[18,19] Courts have upheld mandatory blood testing for HIV of employees during fitness for duty evaluations and of persons convicted of prostitution since mandatory testing "appears rational" and has a "reasonable relation" to state interests.[20,21] Importantly, although HIV, a disease extremely unlikely to be contracted by the examining physician, shaped many public health laws, it fails to prepare society for an airborne pandemic easily spread like COVID. [22]

Courts have a higher standard in cases involving fundamental rights, such as mandatory confinement, or when rules govern groups with immutable characteristics, disenfranchisement, and a history of encountering discrimination.[23] When dealing with infection control, persons must be compared by their risk of transmitting disease instead of other characteristics. For example, in 1900, during an outbreak of bubonic plague, San Francisco ordered a quarantine only for those of Chinese descent. A federal court ruled this practice was racially motivated and unconstitutional.[24]

Additionally, due process requires that individuals be offered opportunities to object to limitations of liberty. While the U.S. Supreme Court has yet to rule on an infectious disease case, the West Virginia Supreme Court, citing mental health precedent, upheld procedural due process for persons detained for public health reasons, holding that someone being detained for tuberculosis has rights to notice, legal representation, an opportunity to present opposing evidence, a chance to cross-examine witnesses, and a required standard of clear and convincing evidence.[25]

Mandatory Reporting

An essential part of public health work involves wide-spread testing to identify clusters of illness. Mandatory reporting laws require physicians to report to public health authorities those suspected of having highly contagious illnesses. Surveillance and reporting are regularly justified by the need to protect other citizens. Psychiatrists are not exempt from mandatory reporting laws required of other health providers. While psychiatrists may not be the first doctor to diagnose an infectious illness, it is foreseeable that a patient may discuss public health concerns with a psychiatrist, like recent travel, close sick contacts, or noncompliance with medications or self-quarantine.

Mandatory reporting has been required since the 1800s, when a physician lost a civil suit for failing to report a case of smallpox.[26] The Supreme Court, in *Whalen v. Roe*, explicitly described certain disclosures of private information to public health agencies as "often an essential part of modern medical practice" (Ref. 27, p 602). The Health Insurance Portability and Accountability Act (HIPAA) allows some disclosures of identifiable data from health care workers to public health authorities without individual written authorization.[28]

In this pandemic, testing and screening remain controversial for some, as the government attempts to obtain individual private health data. Furthermore, racial, ethnic, and gender discrimination affects how the public perceives health screening.[18] Some diseases, such as HIV, have a particular stigma attached, raising privacy concerns. Courts struggle with the constitutionality of mandatory disclosures of sensitive information, even when intended to promote public health. The Michigan Court of Appeals upheld a law requiring known HIV carriers to notify their partners.[29] Similarly, the Supreme Court of Illinois upheld mandatory HIV testing of those convicted of prostitution after the trial judge determined the mandatory testing was an illegal search and seizure that violated equal protections.[30] Alternatively, the Supreme Court, in establishing a patient-psychotherapist privilege, found that protecting private information may serve the public interest since the possibility of disclosure could interfere with successful mental health treatment.[31] Ethics conflicts can arise if the law permits data disclosed for public health purposes to be used for other punitive reasons.

Limited guidance exists for treating psychiatrists who discover a patient presents societal danger for

refusing medical quarantine laws. Unlike in treatment settings where many states have public health statutes permitting reporting of otherwise protected information to public health authorities, no clear guidelines exist for reporting public health concerns uncovered during a forensic evaluation.[5]

Detention, Isolation, and Quarantine

One policy to stop the spread of infection is forced detention of those refusing treatment. Courts, however, often prohibit prehearing involuntary detention. This is problematic given the risks of releasing persons with highly contagious disease from emergency medical detention when they are believed to be imminently dangerous because of a SMI. Courts have held that a person with an active tuberculosis infection who refuses treatment or other infection control measures and poses a risk of infecting others, may be detained involuntarily in a hospital, though at least one has specified the detainee retains specific due process rights, similar to those for involuntary detention of those with SMI.[13,25,32]

The Centers for Disease Control and Prevention (CDC) recommends several different state statutes as reasonable approaches to emergency detention for tuberculosis.[33] Interestingly, in New Jersey, a health officer must serve an order of temporary commitment to anyone nonadherent or threatening nonadherence to infection control measures for drug-resistant tuberculosis.[34] Policies recommended by the CDC address detention in a hospital. This is problematic for counties with limited appropriate medical facilities (in fact, the state of California only has two facilities designated for the detention of people with active tuberculosis).[19] The California Court of Appeal, in an influential decision, ordered counties to cease using county jails for civil commitment of people nonadherent to TB treatment.[35] More recently, however, the Supreme Court of Wisconsin allowed for detention in jail of tuberculosis infected people who are not cooperative with treatment as long as facilities provided proper medical care.[36] The Supreme Court has not ruled on this question and it remains unsettled.

Regarding the duty of psychiatrists to patients and the public, the legal system leaves many questions unanswered or open to interpretation. We expect with evolving pandemic infections, new ethics dilemmas will be encountered prior to the establishment of clear guidance from the law or medical organizations. While it is important for psychiatrists to be familiar with current local and state policies, important clinical decisions should be guided primarily by medical ethics. Psychiatrists will need to balance principles of beneficence, nonmaleficence, and autonomy with special pandemic-related public safety considerations. We present dialectical principlism as one approach to guide psychiatrists in resolving these dilemmas.

Psychiatric Role-Based Ethics Framework

Dialectical principlism was developed to assist psychiatrists in analyzing the complex dilemmas that occur when ethics duties conflict and compete with one another. That is, dialectical principlism is most helpful and best reserved for special situations (i.e., not common scenarios) in which ethics guidelines are not sufficiently applicable or conflict with one another. In these gray areas, there is no risk of professional or organizational sanctions regardless of the action chosen. And thus, dialectical principlism is an aspirational model for psychiatrists motivated to determine their most ethical action in situations in which there is no clear consensus on what the right action is. The method operates by identifying the relevant ethics duties and principles, prioritizing them (i.e., ranking their relative importance), and balancing them (i.e., weighing all the ethics considerations favoring the proposed action against all the considerations opposing that action). Opposing duties and principles are prioritized and ranked based on the particular role of the psychiatrist and specific contextual factors.[9,37,38] The model incorporates ethics guidelines from medical and forensic organizations, ethics theories (e.g., principlism, casuistry, narrative, ethics of caring, and normative ethics), and forensic ethics approaches (e.g., Appelbaum's principlism, Griffith's narrative, Candilis and Martinez's robust professionalism, and Norko's compassion).[39–48]

Dialectical principlism attempts to integrate these guidelines, theories, and models, applying them in four steps. The first is to start with the context to determine the presumptive "proximal" duties as well as any relevant "distal" duties (previously, referred to as "primary" and "secondary" duties but changed for purposes of clarity).[9,37,38] The second is to extract relevant ethics principles from the situation categorized by proximal versus distal duties. The third involves weighing and balancing the competing principles using the reflective equilibrium method of Rawls.

Table 1 Duties of a Physician Working in Different Roles as Described by Dialectical Principlism

	Forensic Role	Treatment Role	Research Role	Administrative Role
Primary Societal Value	Advancing justice	Advancing patient welfare	Advancing scientific knowledge	Advancing distributive justice
Proximal Duties	Truth-telling Respect for persons	Respect for autonomy Beneficence Nonmaleficence	Foster internal and external validity of experiments	Allocation of resources for maximal good in the system
Distal Duties	Consideration of the evaluee's welfare Consideration of the retaining attorney's case Consideration of societal expectations for physicians Consideration of personal values	Protecting vulnerable third parties Distributive justice and other societal considerations Consideration of employer or organization Consideration of personal well-being or safety	Consideration of the research subject's welfare via: Fair subject selection Favorable risk-benefit ratio Safety Informed consent Respect for persons	Consideration of welfare of the individual patient receiving care via: Autonomy Beneficence Nonmaleficence

The final step is to apply these weighted duties to the situation to decide the most ethical action.[49]

Three factors determine the weight assigned to principles in dialectical principlism: the role of the psychiatrist, the context of the situation, and the unique narrative of the practitioner, which defines the set of values and societal expectations of the professional role. It is permissible under the dialectical principlism model for psychiatrists to disagree on the ultimate solution to an ethics dilemma as a result of individual differences in considering certain aspects more or less salient when competing duties are balanced based on their unique narrative, consistent with what Griffith asserted under his narrative model.[45]

Although incorporating other models as opposed to competing with them, dialectical principlism distinguishes itself by establishing a hierarchy of ethics considerations prioritized according to the role of the physician. We define "proximal" and "distal" duties based on how integral they are in promoting the primary societal value for that specific role type. Psychiatrists may disagree on the formulation of proximal and distal duties. We present our theoretical conception to assist analyzing complex ethics dilemmas (see Table 1).

Psychiatrists in treatment, forensic, research, and administrative roles all face competing obligations and ethics considerations that are weighed differently based on their particular role type. That is, a different ethics calculus occurs in each role setting. For example, we conceptualize that the proximal duties in the treatment role include the Beauchamp and Childress bioethical principles related to advancing individual patient welfare (i.e., beneficence, nonmaleficence, and autonomy). We consider their distributive justice principle a distal duty, however, as it is less central to how physicians help their patients and more relevant to how care is delivered fairly on a macrolevel.[50] Although proximal duties will most often outweigh distal duties, in special contexts a distal duty may be so strong as to trump competing proximal duty considerations.

Examples of distal duties outweighing proximal duties occur when treating psychiatrists report suspected elder or child abuse to the proper authorities. The distal duty of protecting vulnerable third parties outweighs the proximal duties of autonomy and nonmaleficence. Other examples include a Tarasoff type duty to protect others in situations triggered by the patient's credible threat of imminent violence. In both examples, the context of extreme harm to vulnerable third parties adds significant weight to the distal duty to favor breaching confidentiality to prevent or mitigate violence.

In the forensic role, we designate Appelbaum's truth-telling and respect for persons as proximal duties because they are central to advancing the interests of justice. Distal duties include consideration to the evaluee, retaining attorney, personal ethics, and societal expectations for physicians. In the research role, as Appelbaum noted, psychiatrists have conflicting duties in advancing scientific understanding.[44] We define research proximal duties as principles that maximize the internal and external validity of experiments and distal duties as principles related to fairness, respect, safety, and beneficence for re-search participants. Conflation of research and treatment

roles may lead clinical trial participants to underestimate risks and overestimate potential benefits of experimental interventions because they believe the physician leading the study is considering their individual well-being as primary when it realistically may be secondary to the study. This risk is highest when the researcher is also the treating physician. A similar phenomenon may occur in forensic settings in which evaluees falsely perceive that forensic psychiatrists are there to help them even if informed properly of their forensic role and which side retained them. Physician hospital administrators and managed care reviewers can be seen to have proximal duties to maximize resource allocation with significant distal duties to patient welfare.

We analyze the following hypothetical COVID-19 related ethics dilemmas to illustrate how dialectical principlism works practically for psychiatrists in forensic versus treatment roles.

Illustrative Case with Ethics Dilemmas

A treating psychiatrist in an outpatient private practice setting in California uses telepsychiatry to provide care for patients to reduce the spread of COVID-19. One patient, previously diagnosed with schizophrenia, recently tested positive for COVID-19. The patient informs the psychiatrist of plans to travel to several public places to infect as many people as possible with the virus because he believes the virus will "cleanse" the world of evil and allow "the righteous to ascend to heaven." The psychiatrist judges this to be a psychotic delusion consistent with his past delusions. The patient declines prescribed antipsychotic medications and refuses voluntary hospitalization.

Decision regarding Delusional Patient

The first question is whether the psychiatrist should attempt to facilitate involuntary hospitalization on the basis of dangerousness secondary to a mental illness (one of the criteria sufficient for an involuntary hold in this jurisdiction).

First Step

The first step under the dialectical principlism model is to determine the presumptive proximal duties as well as relevant distal duties. In this example, the psychiatrist is in the treatment role and has the proximal duty of advancing the welfare of the patient. Distal duties and related ethics principles in the treatment role include safety for third parties, societal effects such as the allocation of scarce resources, the psychiatrist's own personal values, the interests of the psychiatrist's employer (or own private practice if self-employed), professional ethics standards for the field, and societal expectations for psychiatrists.

Second Step

The second step is to extract relevant ethics principles from the situation prioritized by proximal versus distal duties. The three most salient ethics principles for this proximal duty derive from Beauchamp and Childress's bioethical principles of beneficence, nonmaleficence, and autonomy. The major distal duty ethics principle is concern for others related to being in a special position to help prevent danger to vulnerable third parties. An ethics dilemma is present here because a strong distal ethics duty conflicts with and might outweigh the proximal duty in the treatment role.

Third Step

The third step uses the situational context to apply various weights to the proximal and distal principles. In this example, the most important proximal duty ethics principles favoring an application for involuntary hospitalization are beneficence and nonmaleficence. Beneficence pertains to the benefit of hospitalizing and treating the patient's acute psychotic symptoms. Nonmaleficence relates to the medical harm of ongoing, untreated psychosis, as well as legal harm, and possible future guilt (i.e., when no longer acutely psychotic) that the patient may experience if he carried out his plan to infect others. Although the patient may experience undesirable consequences as a result of the psychiatrist breaching confidentiality (e.g., temporary loss of civil liberties, firearm prohibition, employment problems, damage to the therapeutic alliance, incarceration in certain jurisdictions, among others), in our opinion the overall effects for the nonmaleficence principle favor an involuntary hospitalization.

Autonomy is the major proximal ethics principle against involuntary hospitalization. Autonomy, or the patient's right to make his own decisions about his medical care and life, favors not breaching confidentiality if the patient has this decision-making capacity. In this situation, however, because the delusions appear to be directing the patient's decision-

making (i.e., the patient may lack capacity), the autonomy principle is not necessarily in conflict with an involuntary hospitalization.

The most salient distal duty in this hypothetical is concern for others to protect third parties. A serious risk of harm to multiple individuals exists if the patient carries out his threat to spread COVID-19. Similar to traditional Tarasoff type duties in this jurisdiction as well as mandated child and elder abuse reporting, consideration of safety for people who could be hurt or killed by patients is warranted. Most of the time, distal duties will be weighted less than proximal duties for a given role type. Only in extreme situations when the suspected potential harm is serious and imminent (e.g., Tarasoff situations) or the harm is directed toward vulnerable populations (e.g., children, persons with intellectual disability, and the elderly) do contextual factors add weight to distal duty principles so that they outweigh the proximal duty considerations of autonomy and, depending how broadly it is defined, nonmaleficence. Short of those extreme situations, the concern for others may still move the balancing of competing ethics principles toward a particular action depending on the dangers involved.

Another aspect to contemplate in this scenario is the expected consequences of various actions based on the context. Although psychiatrists cannot predict future events, they do possess the ability to stratify likely outcomes based on clinical judgment and past experiences with the specific patient. The psychiatrist should consider the probability that the patient will carry out threats to infect others, the deterrent effects of proposed interventions (e.g., involuntary hospitalization, warning potential victims), and the deleterious versus beneficial effects on future treatment with the patient as a result of the intervention (e.g., damaging rapport by breaching confidentiality). The probability of such effects can modify the weights assigned to each principle being balanced.

Fourth Step

The final step is to apply the weighted criteria to determine the most ethical action. In the previous balancing step, we delineated that autonomy is the one proximal duty principle that possibly favors not hospitalizing (albeit much less so if the patient lacks capacity). On the other hand, the two proximal duty principles (i.e., beneficence and nonmaleficence) as well as the unusually strong distal duty to protect third parties given the severity of the threat favor involuntary hospitalization based on dangerousness. The expected utility (both in regard to the patient's wellbeing as well as public safety) of breaching confidentiality to facilitate involuntary hospitalization is greater if the person's desire to infect others is driven by a psychotic disorder that is more likely to respond to intensive psychiatric treatment than a nonpsychotic (e.g., cultural) belief. If the psychiatrist recognizes that the threat to infect others is reflective of significant psychotic delusions such that the patient lacks the capacity to make a decision about psychiatric hospitalization, then the autonomy principle is no longer in significant conflict with competing principles of beneficence and nonmaleficence in these situations.

Involuntary hospitalization could lead to greater insight into how the psychotic illness affected the patient's judgment and behaviors as a stark departure from his more stably-held beliefs when not acutely ill. It is possible that improved insight from treatment would help maintain established rapport with the treating psychiatrist and mitigate nonadherence risks in the future. Therefore, if the psychiatrist determines that the patient's psychosis is the primary contributor to the stated plan to infect others with a potentially deadly virus, we balance the weighted criteria to favor involuntary hospitalization on the basis of danger to others.

Decision with Delusion-Like Beliefs

Now we consider how to modify the ethics calculus when it is more questionable whether the danger of infecting others reflects a psychotic delusion versus a delusion-like belief (DLB), defined as beliefs that resemble delusions superficially but fail to meet strict criteria on closer analysis, and are possibly shared by others in a fringe, religious or radical, political community.[51] As detailed earlier, ethics problems related to involuntary hospitalization occur when dangerous behaviors are not secondary to an acute, treatable exacerbation of a person's SMI.[6] Additionally, when applying involuntary containment in persons with both COVID-19 and severe psychiatric illness, it is important to distinguish if a clear nexus exists between the psychiatric symptom being treated and the purported danger.[52] The dilemma here is what to do when it is ambiguous whether or not a patient's plan

for danger is the product of a treatable illness in jurisdictions where no relevant public health quarantine laws exist to adequately protect society from this type of planned serious harm.

In considering the proximal duty principle of patient autonomy, breaching confidentiality in this scenario will be weighed more heavily against involuntary hospitalization because decisional capacity is preserved if the plan to infect others is a product of a DLB and not a true psychotic delusion. The benefit of an involuntary hospitalization is less if it is expected that the DLB is less likely to respond to treatment. Although the patient may be less likely to respond to antipsychotic medication if he does not have a psychotic delusion, other, nonpsychopharmacological, benefits could still be possible with short-term hospitalizations. The proximal duty principle of nonmaleficence is less in favor of hospitalization than in the first example because there may be little medical harm of ongoing, untreated DLBs versus a psychotic illness, and the potential legal consequences for the patient that would favor not breaching confidentiality to facilitate an involuntary hospitalization are un-changed. The unusually strong distal duty to prevent serious harm to others remains heavily weighted and possibly more so given the concern that DLBs are likely more immutable and not associated with psychotic symptoms (e.g., negative symptoms and grossly disorganized behavior), and thus the patient with DLB may be more capable of carrying out a plan to infect others than the patient with psychosis in the first example.

In this variation of the hypothetical, the competing ethics considerations are weighted differently in determining whether to pursue involuntary hospitalization. The proximal duty principle of autonomy is weighted more heavily against involuntary hospitalization, and the competing principles of beneficence and nonmaleficence that heavily favored involuntary hospitalization for the patient with delusions in the first example, are now assigned less weight in the balancing process. The strong distal duty to prevent serious harm to others remains heavily weighted in favor of hospitalization. Applying the weighted criteria, we would favor not pursuing involuntary hospitalization in this situation in which it is clear the patient's danger is the result of a DLB and not a psychotic delusion. The key situational factor that would be determinative is how certain the psychiatrist is that the belief is not a psychotic delusion.

Ambiguity regarding the delusional nature of the patient's belief is compounded by insufficient guidance from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) in differentiating between delusions and DLBs.[51] Although a recent study demonstrated forensic psychiatrists are capable of reliably identifying delusions from extreme overvalued beliefs and obsessions when provided with adequate definitions,[53] many forensic psychiatrists are unfamiliar with these distinctions. Moreover, psychiatrists in the treatment role likely have little familiarity applying or experience using these definitions in their clinical work.

Thus, if the treating psychiatrist was largely uncertain that the patient's plan to infect others was the result of a psychotic process or a DLB, then the balancing of competing ethics considerations would more closely resemble the first hypothetical that favored involuntary hospitalization. Greater observational data gained through an involuntary hospitalization would help elucidate whether or not a clear nexus exists between a psychotic illness and the danger communicated by the patient. A short hospitalization might also allow the patient to cooperate or further guide interventions to mitigate the risk of harm to others when no relevant public health quarantine laws exist to protect at-risk third parties. Another possible diagnosis to consider is an adjustment disorder with a nexus to the serious dangers. For example, it is possible that the pandemic, being diagnosed with COVID-19, or other acute stressors, triggered clinically significant behavioral and emotional symptoms that in combination with underlying DLBs is motivating the danger planned by the patient to infect others. A relatively brief hospital stay could help resolve this acute danger, returning the patient to his less dangerous usual state of mind and connecting him to resources and care likely to mitigate future violence risk.

Forensic Evaluation Scenario

Finally, we consider how a forensic psychiatrist retained by the defense to evaluate this same person for competency to stand trial in an out-of-custody setting should act with the information that the evaluee plans to spread the virus. The proximal duty now in the forensic role is to foster truth-telling while respecting the person being evaluated so as to not mislead or coerce the person. Distal duty considerations under

the dialectical principlism model would include duties to the person being evaluated, third parties, societal consequences, and the retaining attorney, among others. A forensic psychiatrist learning of the defendant's plan to transmit the virus to others would likely have a compelling ethical desire to protect others from harm. The forensic psychiatrist may not have the same level of concern for the defendant's autonomy as a treating psychiatrist would because of the role difference. Thus, there would be even more weight in the balancing process to favor notification of potential victims and using the information from the defendant to protect third parties. One complication in this forensic role regards the legal constraints for breaching attorney-client work-product privilege. For example, upon informing the defense attorney of this risk for spreading infection, the attorney may care more about the potential prejudicial ramifications of the forensic psychiatrist notifying others to the degree that the attorney invokes attorney-client privilege to prohibit the psychiatrist from disclosing this information in a report or otherwise. In California, attorneys are permitted to consider danger to others when they represent a client, but unlike psychiatrists they are not obligated to do so.

This dilemma illustrates the conflict of what is most ethical in the forensic role and what is legally permissible as well as differences between psychiatric and legal ethics. Depending on the severity of potential harm expected by the defendant spreading his infection, the forensic psychiatrist may determine the ethics risk for violating attorney-client privilege is less than the ethics risk of not stopping a serious and imminent plan to infect others with COVID-19. The complication in this situation is that reporting the individual to preclude dangers to others could also result in unrelated negative legal consequences to the evaluee and violating attorney-client privilege. One option for the forensic psychiatrist is to attempt to work with the defense attorney toward a plan to protect the third parties while also limiting any prejudicial or harmful legal consequences for the client as part of a negotiated deal with prosecutors. Another possibility is that a forensic psychiatrist could set a condition to accepting such cases at the outset to include a clause allowing the psychiatrist to breach confidentiality and privilege if the client poses a serious danger risk (e.g., ongoing child/elder abuse, Tarasoff situations, furthering the spread of a deadly infection, among others). If attorneys refuse such stipulations, psychiatrists have the option to not accept cases when adhering to such confidentiality requirements violates their ethics.

Conclusion

Preventing the spread of disease involves interactions between legal and health systems. Psychiatrists should be aware of public health concerns related to emerging infectious disease to effectively treat and advocate for mentally ill persons and protect society in this and, most likely, future pandemics. It is essential to be aware of local and state policies, statutes, and case law governing individual rights during a pandemic, including the existence of medical quarantine laws.

Many physicians fail to consider or to utilize an ethics-based approach to decision-making when faced with dilemmas, i.e., situations in which ethics considerations conflict such that any action chosen will inevitably violate some principle(s). Psychiatrists may instead resort to other options, such as seeking advice from colleagues, referring to organizational ethics guidelines, or consulting with their malpractice insurance carrier or legal professionals regarding liability concerns. Each of these methods may be insufficient on its own, however, when aspiring to reach the most ethical decision. For instance, although it may be useful to consult with more-experienced colleagues (or those with more knowledge about or sensitivity to ethics questions) to help identify relevant ethics considerations that would have otherwise been overlooked, these colleagues may be less helpful in guiding how to weigh and balance competing considerations. Ethics guidelines from medical and psychiatric organizations cannot apply to every nuanced situation. Furthermore, guidelines can conflict with one another without any indication as to which should take priority, so they cannot always help determine what is most ethical for the multitude of unique situations that arise in practice. The goal of malpractice carriers and risk management professionals is to instruct practitioners on how best to prevent or reduce liability, and not necessarily on what is most ethical, what is best clinically for patients, or what is most protective to third parties. Moreover, depending on the legal professionals' agency, they may guide practitioners on what is best to limit their employer's (e.g., the hospital, medical group, or corporation) liability rather than what is best to limit liability for the individual practitioner.

Practitioners striving to act most ethically and do what is best for their patients and society may sometimes be more willing to assume a slightly increased liability risk out of concern for others. When legal ambiguities exist in the regulation of psychiatry, psychiatrists who act to protect their patients and others are probably more likely to impress a trier of fact than if they acted only to protect themselves from liability if these actions were later challenged in court. Clinical and ethical decisions related to patient care should not be outsourced to attorneys or risk management professionals because their roles and ethics responsibilities differ from physicians in the treatment role. Instead, risk management professionals and attorneys should be advisors, not deciders, in these contexts to help clinicians minimize liability when doing what is right.

The method of dialectical principlism illustrates how psychiatrists can make ethics-based decisions when faced with the dilemma of whether to involuntarily hospitalize a patient who threatens to infect others with COVID-19 when it is unclear whether this planned danger stems from a psychotic delusion or DLB. Most situations do not require the complex analysis of dialectical principlism. But when faced with conflicting considerations, dialectical principlism provides a framework to inform ethics-based decision-making via identifying, prioritizing, and balancing the competing considerations based on role and context. Dialectical principlism can help psychiatrists determine which action is ethically best for an individual across various roles and situational contexts. The model provides a structure to both understand what factors led to a particular ethics-based action and articulate the rationale for the action to others.

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