COVID-19 and involuntary detention – An emergency medicine or emergency management responsibility?

Dr Joel Wilson BMedSci, MBBS, FACEM
St Vincent's Hospital, Melbourne, Emergency Department
joelwilson1979@gmail.com

Dr Jessica Dean BMedSci(Hons) MBBS(Hons) LLB GAICD GDipLegPrac
St Vincent's Hospital, Melbourne, Intensive Care Unit
Monash University Medical School, Associate Lecturer
jessicamaedean@gmail.com

Assoc Prof Nicola Cunningham BMed, MForensMed, MHlth&MedLaw, FFCFM (RCPA), FACEM
St Vincent's Hospital Melbourne, Emergency Department
Victorian Institute of Forensic Medicine, Clinical Forensic Medicine
nicola.cunningham@vifm.org

Abstract

The COVID-19 pandemic has thrown up innumerable challenges throughout the world, especially evident in the healthcare system. In emergency medicine, there is a new urgency around the clinical and ethical dilemmas clinicians face as they make decisions that impact upon the lives of their patients. Emergency clinicians are accustomed to upholding duty of care and acting in the best interests of patients. Clinical judgements are made every day about a patient's capacity to make their own decisions and act with free will.

It is foreseeable that a duty of care owed to a patient may be in conflict with the responsibility to the health and safety of a community. What is particularly fraught for clinicians is the lack of clarity around this potential duty of care to the community, and navigating the potential conflict with duty of care to the patient. How much danger does the community need to be in, and how definable, imminent and specific does that risk need to be? An attempt to protect the community may well constitute either a breach of confidentiality or a breach of duty of care.

This paper will explore the complex issues of respect for autonomy and the principle of non-maleficence, in the setting of COVID-19 and public health orders and illustrate the uncomfortable uncertainty that exists surrounding care of some of the most vulnerable patients in the community when their actions are contrary to public health recommendations.

This article has been accepted for publication and undergone full peer review but has not been through the copyediting, typesetting, pagination and proofreading process which may lead to differences between this version and the Version of Record. Please cite this article as doi: 10.1111/emm.13932

Introduction

Emergency clinicians are accustomed to making decisions that impact on the lives of their patients, including those for patients who are unable to make decisions for themselves. The pandemic has highlighted clinical and ethical dilemmas around duty of care as previously rare conundrums have increased in frequency. What is particularly concerning for clinicians is the lack of clarity around duty of care to the community and when, if ever, does this duty of care take priority over the duty of care to their patient.

How much danger does the community need to be in and how does the clinician quantify such a subjective measure? How imminent and specific does this risk need to be? The law in this area is conspicuously unclear and there is a significant risk that attempting to protect the community may constitute a breach of confidentiality and duty of care to the patient.

Ethical challenges of frontline care during the COVID-19 pandemic

The COVID-19 pandemic has raised ethical challenges for countless industries across the world, and especially in healthcare. Clinicians understand that the principle of duty of care requires that patient care meets an acceptable standard, and when providing care during the COVID-19 pandemic this comes with an increased level of personal risk. Limited supplies of personal protective equipment (PPE) has created challenges with protecting frontline workers,[5] who continue to care for patients, despite the known and sometimes unknown risk to themselves.[3]

A patient who refuses routine testing for COVID-19 during a hospital admission creates a complex ethical dilemma, whereby no matter which course of action healthcare workers decide to take, somebody's rights will potentially be violated. Under occupational health and safety laws, the healthcare workers have a right to be safe at work.[2,10,12] The hospital has a duty of care to protect other patients from preventable exposure. The patient is utilising scarce resources by requiring an isolation room. The rights of every party cannot all be protected.[6] Kopar and colleagues provide a structured framework for considering all stakeholders in this scenario and conclude that the patient should be refused treatment unless the presenting medical complaint is imminently life-threatening. They argue that this patient is free to choose another institution to seek medical attention, and that the only right being violated in this scenario, is the patient's right to their preferred public treatment facility - a right that exists in a privatised healthcare system and does not necessarily translate to more socialist systems.

The above example deals with a patient who is suspected of having a COVID-19 infection but when a patient is known to be COVID-19 positive and refuses to isolate or comply with medical management and public health directives, the challenges become even more opaque. What are the rights and responsibilities of the clinician in this scenario? Is involuntary detention indicated, and is the clinician responsible for carrying out this directive?

Frontline clinicians are familiar with the concept of informed consent. Patients are able to make a decision about their medical treatment if: they understand the information relevant to the decision and how it affects them; retain that information to the extent necessary to make the decision; weigh that information as part of the decision-making process; and communicate the decision in some way.[4] Capacity is the ability of a person to give informed consent to a particular treatment at a particular time. Capacity can fluctuate over time, or a person might have the capacity to consent to some aspects of their treatment but not to others. Any competent patient has the right to refuse any treatment, even if that refusal may result in that person's death. Treating someone who has not provided, or who has refused consent amounts to a trespass to the person, and can give rise to a civil claim of battery under common law.

In an emergency, consent is not required to treat a person when neither the person nor their substitute decision-maker can provide consent. Emergency treatment is defined in the *Medical Treatment Planning and Decisions Act 2016* (Vic), as treatment that is necessary to save a person's life, prevent serious damage to the person's health, or prevent the person from suffering or continuing to suffer significant pain or distress. Similar definitions exist in analogous acts across other jurisdictions.

Clinicians have obligations to their patients; treating them to an acceptable standard, while respecting their patients' right to confidentiality. Duty of care is used in circumstances where an individual lacks capacity and the clinician believes that treatment is in that patients' best interests, for example, the patient who is intoxicated, incapacitated or psychiatrically unwell. The foundation for this premise is that it is reasonable to believe that the patient would likely give their consent, if they were capable of understanding their current situation.

Psychiatrically unwell patients who are unable to provide informed consent for treatment, may also at times require detainment without consent to facilitate their treatment. Although jurisdictional variations exist between the Mental Health Acts across Australasia, the central premise is the same - to use the least restrictive means possible. (See Table 1). Involuntary detention and treatment orders under the Mental Health Acts may apply where: a patient presents to the emergency department who appears to be mentally ill; their illness requires immediate treatment; involuntary detention and treatment is necessary for their health or safety (whether to prevent a deterioration in their physical or mental condition or otherwise) or for the protection of members of the public; they have either refused or are unable to consent to necessary treatment; and there is no less restrictive way for them to receive adequate treatment. In the same vein, a psychiatrically unwell patient who is suspected of a COVID-19 infection, or who is a COVID-19 positive patient, may be held in quarantine while receiving treatment under the Mental Health Act for their mental illness. The logistics of enforcing such a scenario becomes complicated when considering the risk of infection to the mental health workers caring for such a patient, and the risk to the other patients housed in the same facility.[8]

A result, a refusal, and a clash of responsibilities

Prior to the COVID-19 pandemic, most senior clinicians would be comfortable with the notion that a patient's decision to refuse medical treatment and leave hospital against medical advice must be respected, if they are assessed as having capacity to make an informed decision at that time. However, in the current pandemic the potential risk to the community, other patients, and staff, also weighs heavily on the clinician's mind.

Consider a homeless patient who presents to an emergency department, with a dual diagnosis of substance use and a mental health disorder, who is found to be infectious with COVID-19. This patient would ideally be quarantined until such time as they were no longer infectious. Now consider that this patient refuses admission to a health or quarantine facility and wants to leave, but is not able to give an account of where they will stay, only indicating that they may sleep on the streets or find refuge in a homeless shelter. This patient is assessed by an emergency clinician as not suffering an acute medical condition requiring hospital admission and assessed by a mental health clinician as having chronic fixed delusions but with full capacity to make their own decisions regarding medical and psychiatric treatment.

Is the emergency clinician obliged to physically and/or chemically restrain and detain this patient in hospital to protect the wider community from an infectious threat? Restraining a patient in an emergency department comes with a level of risk to both the patient and the staff, even without the added hazard of a highly infectious virus. Is the clinician's responsibility to protect the patient and staff from a real and present risk more important than the responsibility to the wider community of a potential and more abstract public health risk? If not, which agency is responsible? What is the most appropriate process and facility to house this patient? At the time of writing no secure quarantine facility exists for detaining such individuals, as neither hospitals, prisons, nor remand centres are built for this purpose and the risk to staff, residents and inmates is unacceptably high.

In this situation, the emergency clinician's responsibility is not only to the patient, but also to the community, to protect others from the infectious risk posed by the patient. Whether a clinician owes a legal duty of care to the community at large remains to be seen. As yet, the Courts have not recognised such a duty. There may, however, exist an ethical obligation to the community, which is reflected in community expectations of the healthcare profession.

It could be argued that the most appropriate course of action would be to enlist the assistance of relevant stakeholders, such as the Department of Health, law enforcement, legal units and hospital executives as early as possible to explore the feasibility of options. A possible outcome would be the use of a Public Health Order (PHO) specifically requiring this patient to isolate (See Table 2). Historically, this power has only been used in situations where a significant risk to the community is perceived and a breach of these orders is then grounds for arrest or detainment.[11] In Victoria, such an order must be brought before a magistrate who can issue a warrant for the arrest of the patient, which may include specific conditions around the examination, testing or isolation of the patient, but there remains the issue of the appropriate facility to detain this patient. It could also be argued that the use of these orders to arrest or detain an individual may be in breach of international human rights law.

Conclusion

The Mental Health Acts and the principle of the duty of care are well understood and provide clear pathways for when a clinician may be required to breach the rights of the patient. During the extraordinary circumstances of a pandemic, where the individual's decisions can have a significant impact on the health and safety of others, a clinician's responsibility to the community is considered alongside the principles to protect the patient. Any actions taken to prevent community exposure to an uncooperative COVID-19 positive patient potentially constitutes a breach of confidentiality or autonomy.

Healthcare workers should not be responsible for detaining a COVID-19 positive patient who is unwilling to isolate and who does not fall under a Mental Health Act or the clinician's duty of care, but what is the ethical and legitimate course of action in such a situation? It remains to be seen whether notifying external stakeholders would constitute a breach of confidentiality and the ambiguity is untenable. Clinicians need a clear understanding of the circumstances in which the responsibility to the community outweighs the duty to the individual patient. Consistent and coherent legislation across the jurisdictions is the only way to avoid potential consequences for clinicians when they make decisions within such an ambiguous framework. Until such time, the only clear course for clinicians is to be guided by ethical principles and make every attempt to protect and preserve the autonomy of the patient in front of them.

Table 1. Mental Health Legislation in Australia and New Zealand

Jurisdiction	**Relevant Legislation**
Australian Capital Territory	*Mental Health Act 2015* (ACT) s 37
New South Wales	*Mental Health Act 2007* (NSW) s 19
Northern Territory	*Mental Health and Related Services Act 1998* (NT) pt 6 div 1
Queensland	*Mental Health Act 2016* (Qld) s 50
South Australia	*Mental Health Act 2009* (SA) s 21
Tasmania	*Mental Health Act 2013* (Tas) s 23
Victoria	*Mental Health Act 2014* (Vic) pt 4 div 1
Western Australia	*Mental Health Act 2014* (WA) ss 26, 28, 34, 36

New Zealand	*Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ) ss 8, 8A, 8B

Table 2. Public Health Legislation in Australia and New Zealand.

Jurisdiction	Legislation	Persons Responsible	Power
Australian Capital Territory	*Public Health Act 2007* (ACT) div 6.3 s 115A, 116	Chief Health Officer	Confined to a stated place for a stated period
New South Wales	*Public Health Act 2021* (NSW) pt 4 div 2 s 62.4(a)	Chief Health Officer or Authorised Medical Practitioner - Appointed by Secretary	Detained at a specific place for the duration of the order
Northern Territory	*Public and Environmental Health Act 2011* (NT) pt 4 div 2	Chief Health Officer plus Local Court	Take a particular action, stop engaging in particular conduct or do anything the court considers necessary
Queensland	*Public Health Act 2005* (Qld) div 2,3	Authorised person plus Magistrate for enforcement	May take steps to remove or reduce the risk
South Australia	*Public Health Act 2011* (SA) pt 10, div 2, s 77.5a	Chief Public Health Officer (initial) plus Supreme Court review (extension)	Apprehend, detain, restrain and use reasonable force
Tasmania	*Public Health Act 1997* (Tas), pt 2 div 2	Director of Public Health plus Magistrate	Detain, isolate and quarantine until the Director of Public Health or Magistrate are of the opinion this is no longer necessary.
Victoria	*Public Health and Wellbeing Act 2008* (Vic) ss 117 - 123	Chief Health Officer or Authorised Medical Practitioner plus Magistrate	Detain or isolate. Order must be proportionate to the risk that the person poses to public health.
Western Australia	*Public Health Act 2016* (WA) pt 9, div 5	Chief Health Officer	Submit to being detained and/or isolated. Reviewed every 28 days.

New Zealand	*Health Act 1956* (NZ) pt 3	Medical Officer of Health plus Minister	Not stated. Fine $1000 for breaching orders. Section on "*Isolation of persons likely to spread infectious disease*" was repealed in the Health Amendment Act 1993.

Acknowledgement
The authors thank Ms. Trudy Cox for her collaboration and contribution to this article.

References

1. Australasian College of Emergency Medicine. *Clinical Guidelines for Management of COVID-19 in Australasian Emergency Departments* (v5.0), [Cited Dec 2020.] Available from URL: https://acem.org.au/getmedia/78105c4b-5195-43f6-9c91-25dda5604eaf/clinical-guidelines
2. Australian Federal Government. *Work Health and Safety Act.* 137-2011. Federal Register of Legislation. [Cited 31 Jul 2018] Available from URL: https://www.legislation.gov.au
3. Bensimon CM, Smith MJ, Pisartchik D, Sahni S, Upshur RE. The duty to care in an influenza pandemic: a qualitative study of Canadian public perspectives. *Soc Sci Med* 2012; 75(12): 2425-2430
4. Cameron P, Jelinek G, Kelly AM, Brown A, Little M. *Textbook of Adult Emergency Medicine*, 4th edn, Churchill Livingstone, London, UK
5. Geppert CMA. The Duty To Care and it's Exceptions in a Pandemic, *Federal practitioner : for the health care professionals of the VA, DoD and PHS*, May 2020; 37(5):210-211
6. Kopar PK, Kramer JB, Brown DE, Bochicchio GV. 2021. Critical Ethics: How to Balance Patient Autonomy With Fairness When Patients Refuse Coronavirus Disease 2019 Testing. *Crit Care Explor* 2021; 3(1): e0326.
7. Rangarajan S, McSherry B. To Detain or Not to Detain: A Question of Public Duty? *Psychiatry, Psychology and Law* 2009; 16(2): 288-302
8. Russ MJ, Sisti D, Wilner PJ. When patients refuse COVID-19 testing, quarantine, and social distancing in inpatient psychiatry: clinical and ethical challenges. *J Med Ethics* 2020 46(9): 579-580.
9. Victorian State Government. *Medical Treatment Planning and Decisions Act.* 69-2016, Victorian Legislation and Parliamentary Documents. [Cited 30 Sept 2021] Available from URL: https://www.legislation.vic.gov.au
10. Victorian State Government. *Occupational Health & Safety Act 107-2004*. Victorian Legislation and Parliamentary Documents. [8 Dec 2021] Available from URL: https://www.legislation.vic.gov.au
11. Victorian State Government. *Public Health and Wellbeing Act.* 46-2008. Victorian Legislation and Parliamentary Documents. [Cited 16 Dec 2021] Available from URL: https://www.legislation.vic.gov.au

12. Western Australian State Government. *Work Health and Safety Act 036-2020.* Western Australian Legislation and Parliamentary Documents. [Cited 11 Nov 2020] Available from URL: https://www.legislation.wa.gov.au