



Coronavirus COVID-19

BC Centre for Disease Control | BC Ministry of Health



COVID-19 Ethics Analysis: Intervening When Patients or Residents Pose a Risk of COVID-19 Transmission to Others

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Introduction

Scope

This document applies to all Ministry of Health funded facilities including acute, long-term care, and provincial mental health facilities (tertiary mental health)¹.

While this document does not apply directly to facilities that are not principally settings of care such as assisted living, group homes, supportive housing, or shelters, the ethical principles in this document may offer relevant guidance to those facilities. Application of ethical principles is context-specific and unique circumstances and individual differences may result in differing application between settings. As such, those responsible² for the health and safety of residents in assisted living, group homes, supportive housing, shelters, and other comparable facilities should tailor the recommendations in this document to address context-specific considerations.

Situation

The COVID-19 pandemic presents a number of significant ethical challenges regarding safety considerations in health care settings. This ethics analysis discusses the following ethical question and provides recommendations for consideration:

- **During the COVID-19 pandemic, what is an ethical approach to intervening for a patient or resident³ who cannot (e.g. incapable due to dementia or psychosis) or will not (i.e. capable but non-adherent) adhere to physical distancing and infection control measures and thus poses a risk of harm to others?**

Background

The ethical analysis and recommendations in this document follow the B.C. [COVID-19 Ethical Decision-Making Framework](#) (EDMF). The EDMF reflects the core ethical principles of public health ethics: respect; the harm principle; fairness; consistency; least coercive and restrictive means; working together; reciprocity; proportionality; flexibility; and procedural justice.

Assessment

It is reasonable to consider an escalating degree of intervention when individuals engage in activities or behaviours that put others at intolerable risk of harm⁴, including potential exposure to COVID-19 where physical distancing and infection control measures are not followed. When considering interventions, relevant legislative authority must also be considered.

¹ In this document, these Ministry of Health funded facilities are referred to as “health care facilities”.

² In this document, ethical responsibility is shared by any party who may have a legal or practical role in ensuring the health and safety of residents (e.g., registrants, licensees, or health care personnel).

³ The patient/resident under consideration may have a confirmed diagnosis of COVID-19, may be suspected of having COVID-19, or may not be suspected of having COVID-19.

⁴ Recognizing the subjectivity of the notion of “intolerable risk to others”, assessing this risk should involve a multidisciplinary team-based approach with the inclusion of different stakeholders (e.g. ethicists and/or other professionals). Assessments of risk to others should also take into account all of the ethical considerations in this document for each individual case. For further detail regarding evaluating intolerable risk, see Young, J. & Everett, B. (2018). *When patients choose to live at risk: What is an ethical approach to intervention?* BCMJ, 60(6), 314-318.



Facts & Relevant Information

Key facts based on information currently available

- The COVID-19 virus can be spread to people who are within 2 metres (about 6 feet) of a person who is infected when that person coughs or sneezes.
- The COVID-19 virus can also be passed by touching contaminated surfaces and then touching the face, eyes, nose, or mouth.
- In the context of a global COVID-19 pandemic, B.C. has implemented a number of public health measures to prevent the spread of the virus.
- There is not currently any provision under the law in BC that would allow for routine involuntary testing, for further discussion of involuntary testing, please refer to Appendix A.
- Public health officials have recommended several strategies to mitigate the risk of transmitting COVID-19 including effective hand washing, physical distancing, and self-isolation if symptomatic. For persons with suspected and/or confirmed COVID-19, self-isolation is considered an effective containment strategy and is recommended by the Provincial Health Officer.
- Jurisdictions that have instituted late containment procedures have had more cases and higher morbidity and mortality than those who have instituted containment procedures quickly.
- The risk of harm to others from COVID-19 transmission is potentially significant, particularly in high risk populations, including frail older adults and those with comorbidities. Patients or residents in facilities such as hospitals and long-term care are often the most medically vulnerable due to age and comorbidities and thus may be disproportionately impacted by non-adherence from other patients or residents.
- There is increasing evidence that COVID-19 can survive on surfaces for hours or days⁵. Thus, it is assumed that individuals who do not, or cannot, adhere to COVID-19 containment strategies may be more likely to contribute to community-based COVID-19 spread.
- The potential for a COVID-19 outbreak in a health care facility and the risk of harm to those living or served at that facility must be considered in balance with the possible unintended consequences that may occur as a result of intervening to reduce the risk of transmission, for example, psychological, emotional or spiritual impact which may result from limiting patients or residents' autonomy.

Values grounding this assessment

The Harm Principle

- Society should protect itself from harm.
- In effort to maintain public safety in the present high-risk context, those responsible for the health and safety of residents and persons in care should:
 - Minimize the risk of COVID-19 exposure and spread to the larger population, and
 - Minimize the risk of harm to the specific vulnerable populations currently facing the greatest risk from COVID-19 who constitute the majority of individuals residing in health care facilities; for example, older adults, adults with frailty, adults with chronic health

⁵ As is currently understood, there is some evidence that COVID-19 may survive on surfaces for hours or days. See: <http://www.bccdc.ca/resource-gallery/Documents/Educational%20Materials/EH/FPS/Food/Food%20businesses%20web%20site%20content%20March%202027.pdf>



conditions and comorbidities.

- **Proportionality**

- Options being considered to reduce risk to patients, health care workers, and others to a tolerable level should reflect the particular risks and risk level currently associated with the COVID-19 pandemic.
- After other measures have proven unsuccessful, highly restrictive measures such as the use of restraints may be justified to reduce the risk to the person, other patients or health care workers. These should only be considered where necessary and in compliance with existing legislation. For example, there is no legal provision for the use of restraints in the case of residents of an assisted living residence.
- Where especially invasive restriction of individual freedoms is deemed necessary, measures should be implemented with care and attention to ensure that they are proportionate to and commensurate with the current level of risk associated with COVID-19.

- **Procedural Justice**

- Throughout planning and implementation there must be openness and transparency, inclusiveness, accountability and reasonableness.
- The decision-making process should reflect the best available evidence and ensure assumptions made are well grounded and defensible⁶.
- There should be consistent and transparent communication to all affected patients or residents, those closest to them, and personnel about the decision.

- **Fairness**

- Similarly situated patients or residents should be treated similarly. Decision-makers must be vigilant to ensure that personal bias, unconscious or conscious, does not lead to treating some people in a given situation better or worse based on characteristics about them that have nothing to do with the degree of risk posed to society.
- Healthcare workers, facilities staff and operators should also not assume that patients are equally able to comply with what we require of them in preventing transmission of COVID-19. Ought implies can, and a person cannot be required to do something they are not practically able to do. Some patients or residents have diminished cognitive capacity that affects their ability to comply with physical distancing requirements. This means that in advance of considering an individual unable to comply, staff should consider how to support patients or residents' individual ability to comply with requirements.
- Fairness requires that we appropriately respond to two types of non-adherent patients or residents: (1) those who are not able to comply because of diminished or altered cognition, for example, incapable due to dementia, psychosis, and (2) those who are able to comply but choose not to (i.e., capable but non-adherent). While the combination of listening, seeking to understand, interventions, information and motivation may be fair to (2), (1) may require a different approach.

⁶ The person(s) authorizing and implementing must reflect on how assumptions may relate to personal or institutional biases.



Values in tension with this assessment

- **Respect**
 - Whenever possible, individual liberties and autonomy should be respected.
 - Cultural safety and truthfulness should be practiced by leaders and care providers
 - In the context of a pandemic, individual rights including those of visitation, whether to wash one's hands, or whether to practice physical distancing do not supersede public health safety concerns.
- **Least Coercive and Restrictive Means**
 - All efforts should be made to implement effective measures that are the least restrictive and coercive as possible.
 - As much as practically possible, interventions should be tailored to an individual's specific needs and circumstances, such as age, gender, race, sex, ability, class, trauma history, and barriers to communication.

Discussion

Risk of Harm to Others

In the context of a pandemic, the provincial health system will seek to ensure that individuals do not put others at risk of infection – whether or not the individual in question is or is not capable of complying with measures enacted to contain the pandemic.

In circumstances where the patient's or resident's choice causes intolerable risk of harm to others, those responsible for the health and safety of residents and persons in care have a responsibility to have a documented conversation with the person and those closest to them about choices prior to implementing interventions to reduce risk of harm to a tolerable level.

The intervention used to reduce the risk of harm to others must always be the least intrusive, restrictive and coercive to effectively achieve the desired outcome. As the probability of harm to others increases, and the degree, permanence, and severity of that harm increase, there is greater ethical justification for implementing more invasive mitigating measures to limit the probability and severity of harm.

Unlike behaviours that are only likely to harm a capable patient or resident themselves, for example, eating at risk...etc., intervening may be ethically justified to reduce harm to a tolerable level when the risk of harm to others is significant, regardless of whether the patient or resident in question has capacity.

However, **any intervention used must always be:**

- The least intrusive possible, while effective.
- Used in accordance with the applicable health authority policy, applicable MHO guidance, and in compliance with relevant legislation, such as restraint requirements in the Residential Care Regulation.



When intrusive measures such as restraints are deemed necessary, the imposition of such measures creates an obligation on those authorizing and implementing those measures to determine how to best support those patients or residents impacted through dialogue with the patients or residents themselves, or those closest to them. That is, the person authorizing and implementing must address the infringement on patient or resident autonomy as the patient or resident may not understand and/or agree with what is happening to them. When considering interventions, the individual's rights and freedoms and relevant legislative authority must always be considered.

Degree of Intervention

When deciding on the degree of intervention to mitigate the risk to others, the proposed intervention should (a) be effective, (b) not create other and greater harms than the health care professionals, facility staff and owner/operator seek to prevent, (c) be minimally restrictive yet effective, (d) be non-discriminatory, and (e) if at all possible, be thought justifiable by the patient or resident. Interventions to mitigate risk should also aim to minimize conflicts among ethical principles.

Based on the risk analysis of harm to others, action may be taken even if this means denying a person's agency. When intervening to reduce risk to others to a tolerable level, ethical process includes, as much as possible: inclusion of the team⁷, engaging with patient/resident/substitute decision makers, transparency of process and outcomes, implementing appropriate interventions, setting a review date (at which time the need and type of intervention is reassessed), monitoring progress, and documentation (key principles include: cultural safety and humility, translation services) and employing a trauma-informed, recovery-oriented, and relational approach.

Recommendations

Legal interventions such as those authorized by the *Public Health Act*, *Mental Health Act*, *Health Care (Consent) and Care Facility (Admission) Act*, and/or the *Adult Guardianship Act* may be applicable when considering intervening in patients or residents' activities that pose a significant risk of harm to others. **The focus of this ethics analysis is not to comment on the applicability of specific legislation, but instead, to identify relevant ethical principles and how these apply in such situations.**

1. Where a patient or resident is not adhering to the recommended COVID-19 mitigation strategies such as recommendations pertaining to hygiene, physical distancing, movement within facility and leaving/re-entering facility, and thereby may present a significant risk of harm to others, escalating degrees of intervention starting with the least restrictive measures should be implemented:
 - a. Each case must be examined on its own specific circumstances and involve consideration of the facts – actual as opposed to perceived risks involved. For example, confirmed or suspected COVID-19 cases may be considered as having greater risks to others than individuals who are not suspected of having COVID-19.

⁷ As outlined in Young, J. & Everett, B. (2018). When patients choose to live at risk: What is an ethical approach to intervention? BCMJ, 60(6), 314-318.



- b. Before implementing individual patient/resident interventions, in the interest of using the least restrictive means, consider implementing environmental interventions. For example, consider increasing signage and/or regular security personnel or management staff at entrances to remind people of appropriate behaviors: physical distancing, regular washing of hands, use of hand sanitizer upon entering the building or if not available to wash hands upon re-entry.
 - c. All efforts should be made to understand why the patient or resident is not complying, and to educate, inform, and encourage them to practice transmission mitigation measures. As harms may arise from strategies to mitigate COVID-19 transmission, such as stress, anxiety, and behavioral changes from physical distancing, to the extent possible, consider creative or unique options that might suit individual needs. These may include comforts such as access to entertainment, and non-standard interventions such as the use of redirection and distraction to engage individuals in activities. Consult with the treatment team.
 - d. Clinical management of substance use disorders by an addiction physician including the use of safe supply of pharmaceutical alternatives to toxic street drugs should be offered for anyone who requires isolation due to COVID-19 and who may have a substance use condition. This intervention will promote physical distancing and adherence with public health orders. See [BC Centre on Substance Use Risk Mitigation in the Context of Dual Public Health Emergencies: Interim Clinical Guidance](#)⁸.
 - e. Consider cohorting residents in one area if they are engaging in similar behaviours; for example, leaving the premises and not engaging in physical distancing; and restricting them from entering other resident room areas or common areas to protect other residents. In extreme cases, consider options such as moving a cohort of residents to another site such as a hotel with rooms staffed to meet these residents' needs.
2. If an individual is known or suspected of having COVID-19, or has been exposed to a case of COVID-19, and if adherence with recommended public health measures is not achieved by the above, the most responsible clinician should consult the local Medical Health Officer (MHO), who can help assess risk on a case-by-case basis and provide direction on further management.
3. Recognizing that many patients or residents live with trauma and that restrictions on one's autonomy can be re-traumatizing, restraints (physical, chemical or environmental) should only be used when other mitigation measures have been exhausted, in accordance with health authority policies and standards of care, and in compliance with relevant legislation such as [restraint requirements in the Residential Care Regulation](#). Ethics and Risk Management should be consulted in any circumstance where there are concerns as to whether restraint is appropriate.

⁸ The BC Centre on Substance Use: Risk Mitigation in the Context of Dual Public Health Emergencies: Interim Clinical Guidance relies on the clinical judgment of prescribers utilizing the guidance. It is essential that clinicians consider the recommendations in this guideline in the context of any factors which may increase risk of harm (e.g., concurrent mental health disorders).



4. Decisions should be documented along with the rationale for the intervention being used in accordance with the applicable health authority restraint policy, and in compliance with relevant legislation such as the documentation requirements in the Residential Care Regulation.
5. Where restrictive measures are implemented, regular reassessment should occur. Interventions should be reduced or removed as soon as possible when no longer necessary to manage risk.



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References:

Young, J. & Everett, B. (2018). When patients choose to live at risk: What is an ethical approach to intervention? *BCMJ*, 60(6), 314-318.

PHC, PHSA and VCH (2019). *Risk of Harm: Supporting choices through informed decision-making and collaboration in Long-term Care Homes*.

<http://shop.healthcarebc.ca/PHCVCHDSTs/BD-00-07-40103.pdf>.

Related Policies and Guidance:

- *Interim Guidance to Social Service Providers for the Prevention and Control of COVID-19 in their Facilities* is available on the [Office of the Provincial Health Officer Website COVID-19 page](#) under the heading *Guidance*.
- The *COVID-19 Ethical Decision-Making Framework* is available on the [Office of the Provincial Health Officer Website COVID-19 page](#) under the heading “Health Sector Resources”



APPENDIX A – COVID-19 Testing in B.C.

There may be times when individuals cannot or will not consent to testing for suspected COVID-19. This appendix addresses the following question:

- **In the context of the current COVID-19 pandemic, can health care providers test (swab) a patient or client for COVID-19 without consent when the patient is symptomatic?**

Availability of Testing in BC:

- Confirmatory testing for COVID-19 involves a PCR NAAT (RNA) test for the SARS-CoV-2 virus using a nasopharyngeal (NP) swab. Less invasive testing methods are under development but are not available at this time.
- A variety of serology tests for COVID-19 involving IgG and IgM antibody levels (titres) on blood draws and finger pricks at point of care are being explored. These tests show previous infection with the SARS-CoV-2 virus but at this time we don't know whether they demonstrate immunity to future infection by the same virus.
- Testing time varies depending on testing location, but test results are not generally immediately available.

Initiating Public Health Measures:

- A test result is not required to initiate public health measures that will reduce the spread of the virus if someone is symptomatic.
- If someone has symptoms of COVID-19, under current public health guidance they should be presumed to be positive and the associated measures initiated (e.g., droplet and contact precautions when providing direct care).

Ethical and Legal Considerations:

- Involuntary testing is not generally considered to be ethically justifiable.
- There is not currently any provision under the law in BC that would allow for routine involuntary testing.

Recommendations:

1. If an individual is known or suspected of having COVID-19, or has been exposed to a case of COVID-19, and cannot or will not consent to testing, those responsible for the health and safety of the individual are encouraged to refer to the recommendations on Page 5 of this document.
2. If concerns regarding the individual's possible COVID-19 status continue, it is recommended that the most responsible clinician reach out on a case-by-case basis to reflect concerns to the local Medical Health Officer (MHO). MHOs have the training and capacity to offer a detailed, evidence-based analysis of the risk involved in each individual situation and will take a relational approach to exploring strategies available to mitigate risk.

