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COVID-19 and decision-making capacity

Dr. Ryznar's article "Evaluating patients' decision-making capacity during COVID-19" (Evidence-Based Reviews, Current Psychiatry. October 2020, p. 34-40) provides a cogent overview of the "threshold" or "gradient" approach to capacity evaluations, wherein the assessment of a patient's decisional capacity hinges on the risks and benefits of the specific clinical intervention. From a medicolegal perspective, however, I am concerned that Dr. Ryznar makes a consequential category error in framing sociopolitically-driven noncompliance with infectious disease control measures as a capacity problem. In the United States, public health powers—including the use of isolation and quarantine—fall to properly constituted public health authorities, predominantly at the state and local levels. An infectious patient with suspect ideas about coronavirus disease 2019 (COVID-19) whose decision-making process is not directly compromised by neurocognitive illness does not present a capacity issue, but rather a potential public health issue.

For example, in a controversial 2007 case in Atlanta, Georgia, an attorney with active tuberculosis failed to heed medical advice to refrain from traveling.[1] The patient's uncooperativeness did not implicate concerns over his decisional capacity.[1] However, his international and interstate travel triggered the Centers for Disease Control and Prevention's legal authority under the Public Health Service Act to prevent the entry and spread of communicable disease.[1-3] An authorized order from a duly constituted public health authority is issued and enforceable without regard to clinical determinations of capacity (and is generally subject to challenge via judicial or other due process mechanisms as a government-sanctioned deprivation of liberty to protect public welfare). State laws and local ordinances require physicians to notify the appropriate public health department when patients test positive for certain contagious diseases.

The difficulty with involuntarily detaining a cognitively intact patient due to concern over their contagion risk and erroneous beliefs runs considerably deeper than eliciting a "political backlash" or managing the qualms of hospital security officers. It is a fundamental matter of proper legal authority. Psychiatrists and other physicians assess patients' decision-making capacity for specific treatment decisions on a case-by-case basis, seeking to preserve autonomy while practicing beneficence. Public health officers are agents of the state with designated authorities to control the spread of disease. A capacity determination in the absence of neurocognitive deficits implies the psychiatrist is evaluating the soundness of the patient's ideas as opposed to their cognition, overlooking the reality that fully capable individuals can possess dubious—and even unsalutary—beliefs. While physicians educate patients about the risks of contracting and communicating infection, they are thankfully not tasked with arbitrating sociopolitical disputes at the bedside. Such controversies regarding pandemic response do not belong under the rubric of medical decision-making capacity. Conflating psychosomatic medicine consultations with public health orders risks unmooring capacity determinations from their medicolegal and bioethical foundations.

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The author responds

I appreciate Mr. Kels's letter and explicit discussion of the limits of decision-making capacity. I agree that physicians should not overstep their legal authority and ethical mandate. The specific case discussed in my article was a patient who was symptomatic from COVID-19 who wanted to leave the hospital against medical advice. The contagious nature of this virus certainly falls under the risk/benefit analysis of the clinical situation because it is an important aspect of understanding the nature of the

illness and treatment/recovery process (as a thought example, consider that such a patient lives with their elderly mother who has heart disease and chronic obstructive pulmonary disease, and the patient does not want their mother to die). From a medicolegal perspective, the risk of infection to others may not necessarily outweigh the benefit of autonomy, especially because decision-making capacity assessments are made with the purpose of balancing autonomy and beneficence of the patient, not others. I highlighted the relative importance of autonomy using the weight of the arrows in Figure 2 of my article. I did not task physicians with arbitrating sociopolitical disputes, but merely highlighted how the current climate can impact people's personal views on COVID-19, which sometimes can run counter to scientific evidence. If a patient has an erroneous view about an illness, it is our duty to try to help them understand if it directly impacts their health or affects their decision-making process, especially in a high-stakes clinical scenario.

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Olanzapine for treatment-resistant anxiety

Ms. A, age 62, was a retired high school teacher. Her primary care physician referred her to me for persistent, disabling anxiety. Her condition was recently worsened by a trial of escitalopram, 5 mg/d, which led her to visit the emergency department (ED). There she was prescribed lorazepam, 0.5 mg as needed, which helped her somewhat. Her medical conditions included prominent gastrointestinal (GI) symptoms, with nausea and a restricted diet; tinnitus; and chronic bilateral hand tremors. Her initial Patient Health Questionnaire-9 (PHQ-9) score was 11, and her Generalized Anxiety Disorder-7 (GAD-7) score was 10.

Initially, I encouraged Ms. A to exercise regularly, and I changed her lorazepam from 0.5 mg as-needed to 0.5 mg twice a day. I also referred her to a psychologist for psychotherapy. She showed limited improvement. I increased her lorazepam to 1 mg 3 times a day and started sertraline, 12.5 mg/d, but she soon experienced chest tightness and was admitted to the ED for observation and a cardiac workup. After she visited the ED, Ms. A stopped taking sertraline.

When I next saw Ms. A, she agreed to a trial of olanzapine, 2.5 mg/d at bedtime. Three weeks later, she told me, "I feel so much better." Her scores on the PHQ-9 and GAD-7 were 0 and 1, respectively. Her GI complaints decreased, she had gained a little weight, and her tinnitus bothered her less. Lorazepam was gradually decreased and stopped.

After approximately 2 years, Ms. A had experienced no long-term adverse effects. We agreed to gradually discontinue olanzapine. Over the next 4 months, Ms. A decreased and stopped taking olanzapine at her own discretion.

Three weeks after she stopped taking olanzapine, Ms. A reported that her psychiatric and GI symptoms had returned. She still maintained weekly visits with her psychotherapist. Her GI specialist asked if I could prescribe her olanzapine again. I restarted Ms. A on olanzapine, 2.5 mg/d at bedtime. By the next month, she said she felt much better (PHQ-9: 0; GAD-7: 1). I last saw Ms. A approximately 1 year ago.

Over the years, I have usually prescribed low-dose olanzapine alone or with other medications for patients with treatment-resistance who had no overt psychotic symptoms, I have used this medication for patients with "soft" psychotic thinking marked by severe anxiety, obsessions, compulsivity, perfectionism, and/or rumination.[1] Evidence suggests olanzapine also may be effective for anorexia nervosa.[2] There is good evidence for its use in the DSM-5 diagnosis of avoidant/restrictive food intake disorder ("a food avoidance emotional disorder").[3,4] In retrospect, Ms. A also likely met the criteria for the diagnosis of unspecified eating disorder. Despite extensive GI workup and follow-up, physical signs of GI pathology were equivocal.

Among antipsychotics, olanzapine most closely resembles clozapine, the only antipsychotic that has been proved more efficacious than others for psychotic symptoms.[5] There is also some research suggesting that olanzapine may be more efficacious.[6] Obsessions and perfectionism are associated with dopamine D4 receptor activity, and D1, D2, and D3 receptors are involved in normalizing cognition and reward.[7] There are appropriate concerns about adverse effects, especially metabolic syndrome and obesity, with olanzapine, but patients can have different profiles of receptor sensitivity. In my conversations with Ms. A's primary care physician and GI specialist, metabolic syndrome was not an issue. Clearly, low-dose olanzapine was very helpful in her treatment.

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Neuro-politics and academic paralysis

I commend Dr. Nasrallah for his brief, precisely defined, scientific editorial "Neuro-politics: Will you vote with your cortex or limbic system?" (From the Editor, Current Psychiatry. October 2020, p. 14-15,63). Furthermore, he has demonstrated an admirable intellectual juggling ability to discuss politics while staying off it. This is no easy task when we witness stress, fear, and loathing from the media in the streets and academic institutes.

I would like to see Current Psychiatry and the academic psychiatric community dig deeper into what I will term as the emerging academic paralysis. Psychiatric forums and publications have been sheepish about addressing, probing, and analyzing the bitter divisions in the United States and in other nations. It appears apropos to Dr. Nasrallah's editorial that the limbic system has trumped the prefrontal cortex. As in adolescence, this process has risks, because brain regions governing reward, impulsivity, and sensation-seeking have become—due to the choice of the "Bon Ton" political-correctness church—more influential than higher-order cognitive regions regulating behavioral inhibition, decision-making, and planning,

Similar to a hurricane or tsunami that pushes water into a river, this retrograde shift of feedback pathways is demonstrated by emotional narratives that have flooded the public and drowned facts and evidence-based practice. Furthermore, the science of convenience has emerged, where facts are eligible only if they justify the narrative. Any discussion, debate, or questioning of the rationale of the approach is met with hostility, naming, shaming, and even loss of employment at universities. I have sadly learned from frightened colleagues and from reading reports by academicians whose publications have been either rejected or coerced for revision following acceptance by a peer-reviewed journal or even retracted post-publication due to complaints, harassment, and threats by the politically correct "thought police." Diversity of thinking and freedom of speech—core values and principles in academic dialogue—have been violated. Academicians are as perplexed as laboratory rats that need to learn which lever to push in order to receive a reward and avoid punishment in an ever-shifting environment. People have been pondering, "Is it time for flight, fright, or fight?" As Buffalo Springfield's legendary Vietnam 1960s–era song "For What it's Worth" states: "There's battle lines being drawn and nobody's right if everybody's wrong."

What we have learned from history is that the majority of people exercise passivity and hope as bystanders in order to avoid becoming victims of "collateral damage." Are there no modern Giordano Bruno (the martyr of science), Copernicus, or Michelangelo who would challenge the "Church of the People" that has created new language, terminology, and culture and is on the verge of creating nouveau scientific principles that could lead to a monopoly of one segment of society that threatens pluralism of thought. Do we need dystopic books such as *1984* or *Fahrenheit 451*, or the experience of the French and Russian revolution (epitomized by the guillotine and the gulag) to remind us that we are a step away from education and reprogramming camps that used to be called universities? The American Association of University Professors' most recent announcement on academic freedom ominously avoids using terms such as freedom of speech, diversity of opinions, or even pluralism.

I hope that psychiatrists will lead the way back to sanity, starting with focus groups and forums. It would amount to a group cognitive-behavioral therapy of immense proportion following a paradigm of "Problem Solving," according to Albert Bandura's social learning model. There is simply no other constructive way to get to the cheese at the end of the maze.

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