Limiting Patient Autonomy: Mandatory COVID-19 Diagnostic Testing

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Despite the important clinical and public health implications of a COVID-19 diagnosis, respect for autonomy allows patients to decline testing without explanation and with impunity. Whether physicians believe a test is indicated for clinical care of an individual patient, prevention of nosocomial transmission, or the greater public health, patients may refuse. Such refusals may be increasing due to quarantine requirements, concerns regarding contact tracing, and the persistent absence of a curative treatment.[1,2] Mass screening of all healthcare workers (HCWs) is being considered to prevent hospital transmission,[3] and universal screening in nursing homes has thwarted outbreaks while providing data to facilitate resource allocation.[4] Given these circumstances, patients' absolute right to refuse a noninvasive test with the potential for multifaceted downstream benefit is worthy of reconsideration, in favor of mandatory testing. Mandatory testing confers numerous benefits, including mitigating risk to other patients and HCWs, who play a central role in pandemic response. Because infected HCWs may transmit the virus to patients, they also should undergo mandatory testing,[3] particularly in the presence of symptoms, since nasal secretions increase the diagnostic yield of testing.[5] Although pretest probability (as an estimate of disease prevalence) typically determines the testing strategy for admitted patients, model-based analyses suggest that testing every 3 days for HCWs or continuously hospitalized patients would nearly eliminate infectivity.[6]

Tools for assisting frustrated HCWs navigating patients' right to refuse testing have been developed that incorporate education, clear communication, and conflict resolution.[7] Such approaches are, however, only moderately successful, making personal protective equipment (PPE) based on a default assumption of COVID-19 positivity common.[8] The burden and disheartening waste created by low-yield PPE use among patients unwilling to be tested becomes particularly evident in the context of shortages. Such vexing, stressful shortages, as well as the dual responsibilities of hospitals as stewards of both individual patient and population health, serve as reminders that efficient allocation of resources must be valued alongside the autonomous rights of patients.[9] Moreover, recent reports suggest that test avoidance is a growing problem.[1,2] Refusal to accept testing may be rooted in anxiety, concerns about the consequences of a positive result (eg, inability to attend school or work), or a desire for self-determination.[1,2] The hesitancy that leads to refusal may also arise from misinformation, poor public health messaging, distrust in the establishment, and unproductive considerations related to conscientious objection without foundation.[2] Concepts of individual liberty that often underlie steadfast adherence to the principles of self-determination created opposition to masks that antagonized public health efforts to limit the spread of COVID-19. Although influencing inpatients' behavior to benefit both the public and HCWs may be distinct from community settings, the attitudes that lead to test refusal and defiance of mask-related ordinances likely have substantial commonalities.

THE PATIENT ROLE IN HEALTHCARE DECISIONS

As a pillar of ethical decision-making, patient autonomy plays a powerful role in healthcare decisions in the United States. Whereas values such as beneficence, nonmaleficence, advocacy, and distributive justice impact certain decisions, patient autonomy has evolved into the dominant value. Although the beneficence model had historically guided medical decision-making, the bioethics community spearheaded the emergence of the autonomy model during the past several decades.[10] Benevolent deception (ie, therapeutic privilege) and medical paternalism were central features of the beneficence model.[11] However, the cornerstone of the autonomy model is informed consent, which provides assurance that patients will be neither deceived nor coerced.[10] Professionalism has always presupposed that the beneficence model would result in decisions directed at both improving patient health and minimizing individual patient harms. The public good and consequent positive externalities were acceptable considerations in decisions based on therapeutic privilege before the autonomy model became dominant. In keeping with the philosophical underpinnings of this approach, advocacy for the public health is still considered a justification for limiting informed consent and breaching confidentiality for disease reporting and contact tracing.[9]

ANALOGOUS EXPERIENCES: ETHICAL LESSONS AND PRACTICAL IMPLICATIONS

In non-healthcare settings, the controversies surrounding vaccination and access to schools for unvaccinated children are perhaps the public and professional debate most analogous to COVID-19 testing refusal.[12] Although policymakers may

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distinguish between testing and vaccination, these interventions similarly hold the potential to limit disease incidence and mitigate health impact. To preserve public health, most states prevent (with varied exemptions) unvaccinated children from attending schools. COVID-19 testing may in the future become a requirement for participation in group social activities, athletic competitions, or physical presence in the workplace to facilitate quarantining and/or targeted use of PPE for transmission risk reduction. Given the dramatic mitigation benefits accruable on college campuses,[13] required testing for in-person learning has become common.

There are also parallels, and therefore lessons, to be drawn from experience in testing for HIV, although HIV-related stigma and devalued status of the marginalized populations initially infected impacted the broader societal view of HIV compared with COVID-19. For example, antenatal HIV screening of pregnant women is strongly recommended to facilitate interventions that reduce the chance of vertical transmission.[14] The limitations of purely elective testing are one justification for the current standard of opt-out screening. However, in this case, the health complications of refusal are largely the burden of the fetus, over whose future the mother holds a great deal of choice and responsibility, irrespective of HIV status. The public health implications of HIV test refusal are far less immediate than for COVID-19 infection because there is no effective curative therapy for COVID-19 and spread occurs through nonintimate, unintentional, and unpredictable exposure.

Translating societal attitudes and practices into the healthcare setting to consider mandated COVID-19 testing requires additional considerations related to both patients and providers: (1) HCWs have committed to a set of values and professional obligations that include tasks requiring risks[15]; (2) the public expects HCWs to perform their duties according to a social contract that has few restrictions[16]; (3) limiting patient access to hospital care due to COVID-19 testing refusal would contradict and create conflicts related to professional conceptions of hospitals and physicians as patient agents[15]; and (4) patients who conscientiously object to testing may seek healthcare less diligently, which may lead to health decrements. The associated postponement of essential care may unduly burden the healthcare system, particularly in situations such as ambulatory care–sensitive conditions.

HEALTHCARE WORKER PROTECTION, PATIENT ACCESS, AND THE VALUE OF PARSIMONY

The extent to which the public health justification for mandatory testing extends to hospitalized patients to protect HCWs is ambiguous. HCWs are of enormous instrumental value and are therefore essential for the pandemic response and health of the broader population. Their protection may therefore justify curtailing informed consent for diagnostic testing. Downstream effects on the supply of frontline HCWs may be realized. Poor control over working conditions may negatively impact motivation among HCWs. In addition, they may feel disenfranchised while obligatorily taking personal risks in caring for patients unwilling to commit to the common good through diagnostic test consent. Hospitalized patients who refuse testing may remain patients under investigation (PUIs), thus requiring special respiratory precautions (SRP) throughout their hospitalization, thereby placing a persistent burden on those with responsibilities requiring patient contact.[17] Repeatedly donning and doffing PPE may remind at-risk HCWs that a myriad of benefits may accrue from frequent, ubiquitous testing. Their motivation may be tempered by the demoralizing requirement to care for patients who will not consent to a simple test, knowing that an opportunity to diminish the burdens of this communicable disease that has taken the lives of many HCWs is being relinquished.

Although HCWs could use SRP universally, their selective application in rooms of known COVID-19–positive patients and those with temporary PUI status has several advantages.[17] First, we learned that HIV testing on patients was helpful in enabling surgeons to selectively implement special precautions among infected patients rather than universally applied intensive precautions. Even in the setting of high rates of HIV infection and educational interventions, HCWs do not reliably apply protective measures included in universal precautions.[18] In keeping with these experiences, limiting the number of patients on SRP will minimize the "precautions fatigue" that drives nonadherent behavior among HCWs.[17] As a result, minimizing the proportion of patients on SRP through testing (and liberation from unnecessary precautions in most cases) will improve uptake of crucial hand hygiene practices and adoption of vigilant PPE use. Second, definitive knowledge of COVID-19 status will increase patient access to care because, whether by personal choice or policy, many HCWs limit in-person contact with patients who are or may be COVID-19 positive. For example, many inpatient dialysis units do not accept patients without a negative COVID-19 nasal swab. Physical therapists may delay or avoid seeing a PUI, which will pose challenges for efficient determination of discharge disposition. Third, selective use of SRP will limit the environmental impact of disposed PPE, which is neither recyclable nor biodegradable. Infectious or regulated biomedical waste products are a significant source of environmental pollution, and the World Health Organization has recommended parsimonious, selective use of PPE to minimize the adverse environmental consequences of biomedical waste products.

CONCLUSION

In summary, there are substantial justifications for mandatory testing for COVID-19 in the hospital for HCWs and patients, as has been successfully piloted in selected long-term care facilities. Patients who refuse to allow testing may have to accept that their care may be compromised. For preservation of HCW supply and maintenance of HCW morale, hospital policies should make explicit, without punishment or coercion, that HCWs may modify the care they provide to patients who refuse to consent to COVID-19 testing.

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