



# Coronavirus COVID-19

BC Centre for Disease Control | BC Ministry of Health



## COVID-19 Ethics Analysis: Intervening When People Pose a Risk of COVID-19 Transmission to Others & Clarification of Consent Requirements for COVID-19 Testing

January 18, 2021



Ministry of Health



BC Centre for Disease Control

**If you have fever, a new cough, or are having difficulty breathing, call 8-1-1.**



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## Introduction

On March 11, 2020, the World Health Organization (WHO) declared COVID-19 a global pandemic. British Columbia (B.C.) followed by declaring a public health emergency under the province's *Public Health Act*, and a provincial state of emergency under the *Emergency Program Act*.

Relevant key facts based on information currently available include:

- SARS-CoV-2, the virus that causes COVID-19, spreads from an infected person to others by liquid droplets when an infected person coughs, sneezes, sings, shouts, or talks.
- For up-to-date information regarding the transmission of COVID-19, please refer to the B.C. Centre for Disease Control.<sup>1</sup>
- In the context of a global COVID-19 pandemic, B.C. has implemented several public health measures to prevent the spread of the virus.
- Consent is required to test a person even if they are not following public health measures. There is not any provision under the laws of B.C. that would allow for routine involuntary testing. For further discussion of involuntary testing and consent, 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 people with suspected and/or confirmed COVID-19, self-isolation is considered an effective containment strategy and is recommended by the B.C. provincial health officer.
- The risk of harm from COVID-19 transmission is significant. People 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 people.
- There is increasing evidence that COVID-19 can survive on surfaces for hours or days.<sup>2</sup> 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 of intervening to reduce the risk of transmission. These include, psychological, emotional, social, or spiritual impacts related to limiting patients' or residents' autonomy.

## Purpose and Intended Use of the Framework

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

- **What is an ethical approach to intervening for people<sup>3</sup> who cannot (e.g., incapable due to dementia or psychosis) or will not (e.g., capable but non-adherent) adhere to physical distancing and infection control measures, and thus poses a risk of harm to others?**

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<sup>1</sup> BC Centre for Disease Control. (2020). How it Spreads. Retrieved from <http://www.bccdc.ca/health-info/diseases-conditions/covid-19/about-covid-19/how-it-spreads>.

<sup>2</sup> As is currently understood, there is some evidence that COVID-19 may survive on surfaces for hours or days. See: BC Centre for Disease Control. (2020). Common Questions. Retrieved from <http://www.bccdc.ca/health-info/diseases-conditions/covid-19/common-questions>.

<sup>3</sup> 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.

The ethical analysis and recommendations in this document follow the B.C. [COVID-19 Ethical Decision-Making Framework](#) (EDMF).<sup>4</sup> The EDMF reflects the core ethical principles of public health ethics pertaining to both substantive and procedural considerations. Ethical principles for this document can be found in [Appendix B](#).

## Assessment

It is reasonable to consider an escalating degree of intervention when individuals put others at intolerable risk of harm.<sup>5</sup> This harm could include potential exposure to COVID-19 in instances where physical distancing and other infection control measures are not followed. When considering interventions, relevant legislative authority must also be considered.

## Scope of this document

This document applies to all B.C. Ministry of Health regulated facilities including acute care, long-term care and assisted living, and provincial mental health facilities (tertiary mental health).<sup>6</sup>

While this document applies directly to people in health-care facilities, the ethical principles and values in this document may offer relevant guidance to visitors and people in other settings (such as non-ministry funded assisted living, group homes, supportive housing, or shelters).

Application of ethical principles and values is context-specific where unique circumstances and individual differences may result in differing application between settings and situations. As such, those responsible<sup>7</sup> 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.

## Ethical Principles and Values

Further information on the foundational ethical principles that support this framework can be found in [Appendix B](#).

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<sup>4</sup> Government of B.C. (2020) COVID-19 Ethical Decision Making Framework. Retrieved January 21, 2021 from [http://www.bccdc.ca/Health-Professionals-Site/Documents/COVID-19\\_Ethical\\_Decision\\_Making\\_Framework.pdf](http://www.bccdc.ca/Health-Professionals-Site/Documents/COVID-19_Ethical_Decision_Making_Framework.pdf)

<sup>5</sup> 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.

<sup>6</sup> In this document, these Ministry of Health funded facilities are referred to as “health-care facilities”.

<sup>7</sup> 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).

## 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 the individual in question is capable of complying with measures enacted to contain the pandemic or not.
- 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 their substitute decision maker (if applicable) about choices prior to implementing interventions to reduce the 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 increases, there is greater ethical justification for implementing more intrusive mitigating measures to limit the probability and severity of harm.
- 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 decisional capacity.

However, any intervention used must always be:

- The least intrusive possible or coercive, while effective (e.g., reducing risk to a tolerable level in circumstances where there is a risk of harm to others); and
- used in accordance with the applicable health authority policy, medical health officer 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 to determine how to best support those people impacted. This can be done through dialogue with the people themselves, or those closest to them. 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, 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 HCW, facility staff, and owner/operator seek to prevent, be minimally restrictive yet effective,
- c. be non-discriminatory, and 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 infringing on a person’s individual autonomy and choice. When intervening to reduce risk to others to a tolerable level,

ethical process must include wherever possible:

- Inclusion of the team,<sup>8</sup>
- engaging with patient/resident/substitute decision maker (if applicable),
- transparency of process and outcomes,
- implementing appropriate interventions for the situation,
- setting a review date (at which time the need and type of intervention is reassessed),
- monitoring progress, and
- documentation.

Throughout, cultural safety and humility, translation services and employing a trauma-informed, recovery-oriented, and relational approach should be utilized.

## 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 ethical analysis is not to comment on the applicability of specific legislation, but instead, to identify relevant ethical principles and values 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 handwashing, other hygiene measures, physical distancing, movement within facility and leaving/re-entering facility, possibly presenting a significant risk of harm to others, escalating degrees of intervention starting with the least restrictive measures that are best suited for the situation should be implemented:
  - a. Each case must be examined on its own specific circumstances and involve consideration of the facts, including the actual as opposed to perceived risks involved. For example, persons with 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.
  - b. Before implementing individual patient or resident interventions, in the interest of using the least restrictive means, consider implementing environmental interventions that are accessible to all persons. For example, consider increasing signage (include various languages) and/or regular security personnel or management staff at entrances to remind people of appropriate behaviours: physical distancing, regular washing of hands, other hygiene measures, use of face masks, use of hand sanitizer upon entering the building, etc.
  - 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 in a culturally safe way. As harms may arise from strategies to mitigate COVID-19 transmission, such as stress, anxiety, and behavioural 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

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<sup>8</sup> 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.

- non-standard interventions such as the use of redirection and distraction to engage individuals in activities. Consult with the treatment team for suitable options.
- d. Clinical management of substance use disorders by an addiction physician or nurse practitioner, 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 [B.C. Centre on Substance Use Risk Mitigation in the Context of Dual Public Health Emergencies: Interim Clinical Guidance](#).<sup>9 10</sup>
  - e. Consider cohorting people 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 people. In extreme cases, consider options such as moving a cohort of people to another site such as a hotel with rooms staffed to meet these patients' or 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, who can help assess risk on a case-by-case basis and provide direction on further management.
  3. Recognizing that many people 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](#).<sup>11</sup> Ethics Services and Risk Management should be consulted in any circumstance where there are concerns as to whether restraint is appropriate.
  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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<sup>9</sup> B.C. Centre on Substance Use. (2020). B.C. Centre on Substance Use Risk Mitigation in the Context of Dual Public Health Emergencies: Interim Clinical Guidance. Retrieved from <https://www.bccsu.ca/wp-content/uploads/2020/05/Risk-Mitigation-in-the-Context-of-Dual-Public-Health-Emergencies-v1.6.pdf>.

<sup>10</sup> The B.C. 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).

<sup>11</sup> Residential Care Regulation, Community Care and Assisted Living Act, S.B.C. 2002. c. 75, s. 73(1). Retrieved from [https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96\\_2009#section73](https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96_2009#section73).

## Appendix A: Clarification of Consent Requirements for COVID-19 Testing

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 (e.g., swab) a patient or resident for COVID-19 without consent when the patient or resident is symptomatic?**

### Availability of testing in B.C.

- Confirmatory testing for COVID-19 involves a PCR NAAT (RNA) test for the SARS-CoV-2 virus using a nasopharyngeal (NP) swab. Less invasive mouth rinse and gargle sample testing is also available.
- 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 it is not known whether they demonstrate immunity to future infection by the same virus.
- Testing time varies depending on testing location, and test results are generally not 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.
- Currently, there is no provision under the law in B.C. 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 starting on page 7 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. Medical health officers 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.



## Appendix B: Foundational Ethical Principles

This framework is underpinned by the following ethical principles:

### Procedural considerations

- Procedural justice (fair process):
  - Openness and transparency
  - Inclusiveness
  - Accountability
  - Reasonableness
  - Consistency

### Substantive considerations

- The harm principle
- Proportionality
- Distributive justice:
  - Equitable distribution (fairness)
    - Equality
    - Equity
  - Just distribution of benefits and harms, risks and burdens
- Cultural safety
- Respect
- Least coercive and restrictive means

This framework is in tension with the following ethical principles:

- Respect
- Least coercive and restrictive means

Further information on these principles and their intent can be found [here](#).<sup>12</sup>

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<sup>12</sup> Government of B.C. (2020) COVID-19 Ethical Decision Making Framework. Retrieved January 12, 2021, [http://www.bccdc.ca/Health-Professionals-Site/Documents/COVID-19\\_Ethical\\_Decision\\_Making\\_Framework.pdf](http://www.bccdc.ca/Health-Professionals-Site/Documents/COVID-19_Ethical_Decision_Making_Framework.pdf).

## Appendix C: Contributors

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