6. Center for Disease Control and Prevention, "Treatment of Malaria: Guidelines for Clinicians (United States)," April 2019, last reviewed May 11, 2020, https://www.cdc.gov/malaria/resources/pdf/Malaria_Treatment_Guidelines.pdf.
7. "Malaria," World Health Organization, January 14, 2020, https://www.who.int/news-room/fact-sheets/detail/malaria.
8. J. Brewster, "Trump Again Promotes Experimental Drug for Coronavirus Treatment Hydroxychloroquine: 'What Do I Know, I'm Not a Doctor. But I Have Common Sense,'" *Forbes*, April 5, 2020, https://www.forbes.com/sites/jackbrewster/2020/04/05/trump-again-promotes-experimental-drug-for-coronavirus-treatment-hydroxychloroquine-what-do-i-know-im-not-a-doctor-but-i-have-common-sense/#4ff72c9f4609.
9. 7News Digital Staff, "Coronavirus Australia: Clive Palmer's Foundation Buys Millions of Doses of Hydroxychloroquine," *Sunrise*, 7News, April 23, 2020, https://7news.com.au/sunrise/on-the-show/coronavirus-australia-clive-palmers-foundation-buys-millions-of-doses-of-hydroxychloroquine-c-995714.
10. BBC, "Hydroxychloroquine: India Agrees to Release Drug after Trump Retaliation Threat," *BBC News*, April 7, 2020, https://www.bbc.com/news/world-asia-india-52196730.
11. P. J. Guerin, S. Singh-Phulgenda, and N. Strub-Wourgaft, "The Consequence of Covid-19 on the Global Supply of Medical Products: Why Indian Generics Matter for the World?," F1000Research 9 (2020): 225.
12. D. P. Fidler, "Negotiating Equitable Access to Influenza Vaccines: Global Health Diplomacy and the Controversies Surrounding Avian Influenza H5N1 and Pandemic Influenza H1N1," *PLoS Medicine* 7, no. 5 (2010): doi:10.1371/journal.pmed.1000247.
13. M. J. Tosam et al., "Global Health Inequalities and the Need for Solidarity: A View from the Global South," *Developing World Bioethics* 18, no. 3 (2018): 241-49.
14. World Health Organization, Global Influenza Programme, *Pandemic Influenza Risk Management Guidance* (May 2017): https://www.who.int/influenza/preparedness/pandemic/PIRM_update_052017.pdf.
15. S. C. Quinn and S. Kumar, "Health Inequalities and Infectious Disease Epidemics: A Challenge for Global Health Security," *Biosecurity and Bioterrorism: Biodefense Strategy, Practice, and Science* 12, no. 5 (2014): 263-73.
16. N. MacDonald, "H1N1 Influenza Vaccine: Global Access for a Global Problem," *Canadian Medical Association Journal* 181, no. 3-4 (2009): 123.

Duties toward Patients with Psychiatric Illness

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The Covid-19 pandemic is exacerbating long-standing problems within society and health care in the United States. One among them is the protection and treatment of vulnerable psychiatric populations. Psychiatric patients have significantly increased risks of suicide, sudden cardiac death, all-cause mortality, and being victims of violence.[1] Those with psychiatric illness receive poor medical care, and a diagnosis of schizophrenia reduces life expectancy by approximately fifteen years.[2] Additional stigma, lack of reimbursement parity for psychiatric conditions, and a shortage of mental health workers further contribute to their vulnerability.

Patients with severe and persistent mental illness are often less able to advocate for themselves as a function of their symptomatology.[3] Disorganized speech, inappropriate affect, ambivalence about treatment, and difficulty trusting providers may lead to poor communication and misunderstandings. Comorbid substance use may further complicate their conditions and care. Neurocognitive impairments and negative symptoms such as lack of motivation, poor judgment, and impaired executive function may limit their ability to navigate a complex health care system. Many patients with severe and persistent mental illness face additional barriers, including poverty, marginal housing, and food insecurity, and the many challenges that come with any of these factors.

The U.S. health care system is attempting to improve health care access during the pandemic, and its primary strategy has been a rapid expansion of telehealth. The therapeutic potential for telehealth services for mental health care may create new outpatient treatment options for some populations. Tele-mental health care offers both monitoring and delivery of intensive treatment outside of the hospital and is easily scalable. However, the efficacy has yet to be demonstrated, and it may not reach the most vulnerable populations due to lack of Internet access and technological

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The rapid expansion and innovation in tele-mental health services may improve psychiatric access for certain patients while marginalizing others even further.

literacy. Further, disorganization, paranoia, and other symptoms related to underlying illness may become barriers to the use of tele-mental health services when these resources are most critical.

Patients who require psychiatric hospitalization face further challenges. Due to widespread shortages of psychiatric beds, patients may be kept temporarily in the emergency department, an alternative that has been demonstrated to be unsafe, inappropriate, and ineffective.[4] Anecdotal accounts suggest that this phenomenon has worsened during the pandemic and that the excess time that a patient spends in the emergency department now represents an additional risk of infection with Covid-19. There are accounts of emergency departments considering discharging suicidal patients because physicians feel that this condition is less concerning than the acute respiratory syndrome caused by Covid-19. Almost fifty thousand lives are lost every year to suicide. The economic depression and social isolation that have befallen the country in the wake of Covid-19 are expected to increase this already sobering suicide rate.

The medical community has an especially strong duty to protect patients receiving involuntary psychiatric treatment, patients whose freedom and self-determination have been temporarily overruled.[5] A patient who is detained for involuntary psychiatric treatment retains certain rights, and involuntary psychiatric treatment should be efficient, effective, safe, and respectful.[6] Once a patient has arrived at a psychiatric hospital, there is a duty to protect them from risk of infection with Covid-19. Nursing homes, prisons, and homeless shelters are receiving widespread attention for extraordinarily high rates of Covid-19 transmission and mortality, but outbreaks are occurring within psychiatric hospitals as well.[7] It should go without saying that hospitals should take every precaution to protect patients from infection. Contracting Covid-19 during an involuntary psychiatric hospitalization could reinforce patients' paranoia and distrust of the health care system, creating yet another future barrier to adequate medical and psychiatric treatment. It may be appropriate to shift the thresholds between managing psychiatrically decompensated patients in the community, recommending voluntary psychiatric hospitalization, and mandating involuntary psychiatric hospitalization. Safety risk assessments with respect to a patient's psychiatric health should be balanced against the risk of contagion incurred by confinement in a group setting.

Many patients with psychiatric illness experience hardships of our society's and health care system's disparities, and the vulnerability of these patients cannot be overstated. The medical community has an additional duty to provide safe and effective care for patients once we have infringed upon their freedom under the premise of maintaining their safety.

While severe and persistent mental illness presents unique risks, many other psychiatric conditions may be exacerbated by the pandemic. Patients with a history of interpersonal trauma who are living in an unstable family environment are at elevated risk of interpersonal violence, and indeed there has been a surge in domestic violence during the pandemic, with reported increases of up to 700 percent.[8] Patients with obsessive compulsive disorder can become preoccupied with fears of contagion and cleansing rituals. Patients with anxiety and depression are likely to experience a worsening of their symptoms, while health care workers and others on the front line will likely be at increased risk for burnout, moral injury, complex grief, and post-traumatic stress disorder. And everyone faces increased risks of financial stressors, substance use, social isolation, interpersonal trauma, limitations around common coping skills like exercise, or barriers to social support like twelve-step programs and religious communities.

The ripples of the current pandemic and the abrupt changes required for social distancing will be far reaching. The rapid expansion and innovation in tele-mental health services may improve psychiatric access for certain patients, including patients with transportation barriers or those living in rural areas, while marginalizing others even further, given unequal access to technology and technology literacy. Disparities in the social determinants of health have been widely discussed in the media and may prompt renewed efforts to address injustices tightly linked with mental health outcomes. Transmission of infection within psychiatric hospitals has forced recognition of the risks associated with psychiatric hospitalization and stimulated conversation about a patient's right to safety. The light shed on underfunding and gaps within the mental health system will hopefully gain the attention of legislators, the public, and the health care system. Access must be improved by increasing the availability of inpatient psychiatric hospitalization, facilitating efficient transitions in care, offering innovations like virtual partial hospitalization and home hospitalization programs, and finding solutions to reach those with limited technology.

Some portion of the population will likely suffer long-term traumatic sequalae from the pandemic, and many people may require psychiatric treatment. The duty to provide psychiatric care will, no doubt, be tested by the aftermath of

this public health emergency. Though the financial costs to improving the mental health infrastructure may seem substantial, the current circumstances remind us that mental well-being is integral to the economic and social prosperity of a nation's citizens, families, businesses, and institutions.

1. B. Felker, J. J. Yazel, and D. Short, "Mortality and Medical Comorbidity among Psychiatric Patients: A Review," *Psychiatric Services* 47, no. 12 (1996): 1356-63.

2. R. Schoos and C. L. Cohen, "Medical Comorbidity in Older Persons with Schizophrenia," in *Schizophrenia in Later Life*, ed. C. L. Cohen (American Psychiatric Association Publishing, 2003): 17-37; S. L. Krein et al., "Diabetes Treatment among VA Patients with Comorbid Serious Mental Illness," *Psychiatric Services* 57, no. 7 (2006): 1016-21.

3. S. Misra and L. Ganzini, "Medical Care for Patients with Severe and Persistent Mental Illness," *Journal of General Internal Medicine* 21, no. 11 (2006): 1207-8.

4. B. A. Nicks and D. M. Manthey, "The Impact of Psychiatric Patient Boarding in Emergency Departments," *Emergency Medicine International* 2012 (2012): doi:10.1155/2012/360308; K. Nordstrom et al., "Boarding of Mentally Ill Patients in Emergency Departments: American Psychiatric Association Resource Document," *Western Journal of Emergency Medicine* 20, no. 5 (2019): 690-95.

5. D. Kingdon, R. Jones, and J. Lonnqvist, "Protecting the Human Rights of People with Mental Disorder: New Recommendations Emerging from the Council of Europe," *British Journal of Psychiatry* 185 (2004): 277-79; A. Saya et al., "Criteria, Procedures, and Future Prospects of Involuntary Treatment in Psychiatry around the World: A Narrative Review," *Frontiers in Psychiatry* 10 (2019): doi:10.3389/fpsyt.2019.00271.

6. H. Helmchen and A. Okasha, "From the Hawaii Declaration to the Declaration of Madrid," *Acta Psychiatrica Scandinavica Supplementum* 399 (2000): 20-23; P. Bartlett, O. Lewis, and O. Thorold, *Mental Disability and the European Convention on Human Rights* (Leiden, The Netherlands: Martinus Nijhoff, 2007), 75-109, doi:https://doi.org/10.1163/ej.9789004154230.i-382; Office of the United Nations High Commissioner for Human Rights, "Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care," United Nations, 1991, https://www.who.int/mental_health/policy/en/UN_Resolution_on_protection_of_persons_with_mental_illness.pdf.

7. S. Rocheleau, "Coronavirus Spreads to 3 State-Run Facilities for Those with Mental Illness, Developmental Disabilities," *Boston Globe,* April 16, 2020.

8. M. Townsend, "Revealed: Surge in Domestic Violence during Covid-19 Crisis," *Guardian*, April 12, 2020; J. Beddington et al., "The Mental Wealth of Nations," *Nature* 455 (2008): 1057-60.

Vulnerable Children in a Dual Epidemic

by CAROL LEVINE

What will be the short- and long-term impact on vulnerable children and adolescents living through the Covid-19 pandemic, some of whom are also closely affected by the opioid epidemic? Do these experiences count as adverse childhood experiences (ACEs) that should trigger parental and professional concerns and interventions?

Modern bioethics discussions involving children mostly concern reproductive rights, participation in research, or decisions about medical treatment. Disparities in children's health care and educational opportunities are largely seen as long-standing social and economic problems, not immediate crises.

It is reassuring that children have so far not contracted the coronavirus in substantial numbers. Children are not immune, and a few have died, but most do not seem to be at particular risk of infection. A newly recognized syndrome—multisystem inflammatory syndrome-children (MIS-C)—is associated with Covid-19 infection. While rare, it is serious and has been fatal.[1] In addition, Covid-19 poses a higher risk for certain groups of children: those whose immune systems are suppressed because of cancer treatment or other conditions and those who live in congregate settings with little room for social distancing. Most families who live in crowded settings have no other options; some immigrant children have been placed in such settings against their parents' wishes.

Even healthy children in stable settings may not get appropriate health care because their parents are afraid of infection at a pediatrician's office or are overwhelmed by other things going on in their lives. While a routine visit can be conducted by telehealth, children may not get required vaccinations on time, and signs of illness, developmental delays, or abuse and neglect may be missed. At one practice in Berkeley, California, before a visit is scheduled, the child is screened by phone for signs of illness. If the child has re-

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