Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

adoption of personal protective equipment that put the subject's physical and psychological endurance to the test. To face this problem and guarantee the psychophysical well-being of employees, health care facilities must guarantee the adoption of preventive and protective measures, including psychological support through dedicated pathways.

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Capacity and the COVID-19 Surge

TO THE EDITOR: Requests to evaluate patients' capacity to make medical decisions are a routine aspect of consultation-liaison (C-L) practice. The medical culture of different health systems and their surrounding communities define variable thresholds for primary teams to request assistance from psychiatrists in making such determinations. One study suggested that the percentage of inpatient consultation requests may comprise anywhere from 3 to 25% of cases on an inpatient C-L service.[1]

At our urban safety net hospital, the high-volume C-L practice that routinely cares for more than 10% of the acute hospital census has heretofore infrequently been called on for capacity assessments. Medical and surgical teams are accustomed to treating patients with educational and neuropsychiatric limitations who are unlikely to meet formal criteria for having capacity to consent for many of the advanced interventions proposed. Beneficence has always stood more equally alongside autonomy in our hospital to guide the work.

We write to report that, superimposed on this background of our established norms, there was a sudden increase in requests for assessment of decision-making capacity in the wake of the SARS-CoV-2 outbreak. During the 12-month period from February 1, 2019 through January 31, 2020, only 1.8% of nearly 4000 psychiatry consultation orders were placed for evaluation of capacity. Between February 1, 2020 and May 31, 2020, the fraction of requests for capacity assessment nearly tripled to 5.3%. Not unlike other C-L services, we routinely identify issues around decision-making in many evaluations wherein the initial "question" was not about capacity,[1] but we were surprised to have primary teams more frequently calling about this particular issue right after hospital routines and census were altered by coronavirus disease.

We hypothesize that restriction of hospital visitation in the interest of curtailing spread of the pandemic is a major factor. Despite the

baseline reality that many of our patients (along with their friends and loved ones) lack the cognitive and relational skills to be fully capacitated for a range of medical decisions, when they are together in the hospital, they function as living, choosing bodies in ways that reassure primary teams about the path going forward. Having visitors in the room bolsters the patient side of care relationships in a manner to which we have become accustomed. Their absence leaves our internists and surgeons concerned that the patient's voice has lost an amplifier when those visitors are less present and only occasionally connected via remote technology.

The increase in requests for capacity assessment may also reflect heightened concerns about doing the right thing in these difficult times. We have seen what happened in Italy and fear the specter of rationing. So even at this stage with adequate resources for all of our inpatients, there is a desire to ensure the ethical rectitude of our own part in medical decisions and the practice that proceeds from them. There is more pressure to perform our work in a way that not only helps patients and fits with our own professional sense of duty but also holds up under outside scrutiny.

As psychiatrists, our C-L group has also been curious about other layers of meaning embedded in this change in our interdisciplinary experience. Metaphorically and dynamically, it may be that medical teams fear *they* lack some "capacity" in this time. They may worry more about making the wrong decisions about assessment and treatment when the emergence of a new disease and the evolving practice around it leaves standards unclear. Physicians themselves (ourselves?) may lack capacity to manage uncertainties inherent to caring for the sick and vulnerable when the close physical contacts doctors share with their patients to gather information and solidify the bonds of their working relationships have been limited by fear of coronavirus disease spread. We believe our service has been asked to contain more distress through a veiled communication of these concerns in the form of increased requests for evaluation of decision-making capacity.

I have decided that such requests – which on the surface may appear to be an improper use of our resources when the answer to that question about capacity is obvious – reflect a need for which we must exhibit the capacity to be present and helpful to patients and their care teams on multiple levels. C-L psychiatrists have become accustomed to being consulted in unclear ways about unclear things. Now, more than ever with the emergence of a pandemic threat, it is clear to me that the wisdom I attribute to our own Dr. Maryland Pao has never been more relevant – "There's no such thing as a bad consult."

Sincerely,
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Re-examining the Association Between COVID-19 and Psychosis

TO THE EDITOR: We read with great interest the recent report by Ferrando et al.,[1] which described 3 patients who presented to the emergency department with similar symptoms including agitation, disorganization, paranoid ideation, and auditory hallucinations. They were all tested for the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), albeit the method of testing was not specified, and found to be positive for the Coronavirus Disease 2019 (COVID-19). We have some thoughts on the observed association and hope this would generate greater discourse on the subject.

First, possible infective origins of mental illness were probably first hypothesized in 1845 by the French neurologist Jean Esquirol, and the theory was later refined by Swiss psychiatrist Eugen Bleuler in the 19th century.[2] Given the systemic