Consent Issues During a Pandemic: What to Do if a Patient Refuses COVID-19 Testing

Amundsen Davis Health Care Alert
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The United States has tested 3.2 million people for COVID-19, which is only about one percent of the population. It should come as no surprise that not every person who is ill is tested. In fact, the Centers for Disease Control (CDC) issued written guidance on March 24, 2020, prioritizing testing for patients with suspected COVID-19 infections based on certain criteria. Individuals with varying degrees of priority are those who are:

- Already hospitalized;
- Health care workers with symptoms;
- Long term care residents with symptoms;
- 65 years of age or older with symptoms; or
- Individuals with underlying conditions with symptoms.

While it is hard to imagine a symptomatic individual refusing a test in this environment, it is important to consider the legal implications of a patient's refusal and to provide guidance on how to respond while navigating federal and state laws that may apply to the situation.

To provide a framework for this discussion, consider the following hypothetical scenario:

A 42 year-old female patient with no underlying medical conditions comes to the emergency department of Hospital A, a Medicare-participating hospital, with symptoms of a 101° fever, dry cough, and shortness of breath. A flu test done in her primary doctor's office was negative a few days ago. Upon presentation, she refuses to be tested for COVID-19.

First, as stated in a previous post, the Emergency Medical Treatment and Labor Act (EMTALA) requires all Medicare-participating hospitals with emergency departments to provide every individual a medical screening exam (MSE) for an emergency medical condition (EMC), to provide necessary stabilizing treatment for individuals with an EMC within the hospital's capability and capacity, and to

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provide for transfers when appropriate. Every Emergency Department (ED) is expected "to have the capability to apply appropriate COVID-19 screening criteria when applicable, to immediately identify and isolate individuals who meet the screening criteria to be a potential COVID-19 patient and to contact their state or local public health officials to determine next steps when an individual meeting the screening criteria is found."

Note that there is no requirement listed above that individuals coming to the ED must be *tested* for COVID-19. We suspect this may be due to the limited availability of tests and the limited availability of laboratories processing them. Therefore, in our hypothetical scenario, since the patient presented with symptoms consistent with COVID-19, she must be provided an MSE to evaluate whether she requires treatment for an emergency medical condition under EMTALA. According to the CDC, "[p]atients whose clinical presentation warrants in-patient clinical management for supportive medical care should be admitted to the hospital under appropriate isolation precautions." On the other hand, patients with a mild clinical presentation may be monitored outpatient and sent home for self-isolation.

Additionally, keep in mind that, under Illinois law, a patient has the right to refuse any treatment to the extent permitted by law. 410 ILCS 50/3(a). However, when dealing with a refusal to test in the presence of mild symptoms, we recommend that the patient be provided information about the importance of testing and the risks of the condition. Further, we strongly recommend that the refusal is documented clearly in the chart before the patient is discharged. The patient should be provided written documentation about the CDC guidelines to self-isolate and to follow-up if her condition worsens.

While not all suspected COVID-19 cases should be reported, the Illinois Department of Public Health (IDPH) has indicated providers should "**immediately (within 3 hours)** report to the local health department by telephone:

- A cluster of 2 or more suspect cases of COVID-19 among residents of congregate settings (skilled nursing facilities, assisted living facilities, group homes, homeless shelters or correctional facilities) that serves vulnerable populations with onset less than 7 days apart;
- Outpatients with suspect COVID-19 who are employees in residential congregate settings that serve vulnerable populations;
- Any person hospitalized with pneumonia of unclear etiology who lives in or works at a residential congregate setting that serves vulnerable populations;
- Any resident or staff member from a residential congregate setting that serves vulnerable populations, who has laboratory confirmed COVID-19, and whose illness has not been previously reported to the local health department."

Under our hypothetical, the female patient would only be reported as a suspected case if she was an employee of a nursing home, homeless shelter, etc. Therefore, we recommend asking patients questions about their employment as part of the initial screening in the event testing is refused but the patient is suspected of having COVID-19 in the event she falls within one of these categories.

Regardless of the above, there is some legal authority that may permit the state to mandate that a person undergo testing. In *People v. Adams*, the defendants were ordered to undergo HIV testing under Section 5-5-5(g) of the Unified Code of Corrections following their convictions for prostitution. 149 Ill.2d 331 (1992). Section 5-5-5(g) states that any defendant convicted of an offense like prostitution "shall undergo medical testing to determine whether the defendant has any sexually transmissible disease, including a test for infection with HIV." *Id*. at 333-34. The defendants challenged the constitutionality of the statute, arguing that it violated their right to privacy, freedom from unreasonable searches and seizures, and deprived them of equal protection of the laws, as guaranteed by the United States and Illinois Constitution. *Id*. at 335.

The Illinois Supreme Court observed that the statute at issue was among a series of laws enacted by the Illinois General Assembly in response to the growing AIDS crisis. *Adams*, 149 Ill.2d at 337. The court further noted that the challenged provision was a

"public health measure and thus involves a field in which the States exercise broad regulatory and administrative powers. Like other measures intended to enhance public health and community well-being, governmental action designed to control the spread of disease falls within the scope of the State's police powers. Traditionally, the States have been allowed broad discretion in the formulation of measures designed to protect and promote public health."

Id. at 339. However, the "broad mantle of public health does not shield such measures from all scrutiny, for the police power may not be used to violate a positive constitutional mandate." *Id*. at 339-40.

The court determined that "[t]here are few, if any, interests more essential to a society than the health and safety of its members. Toward that end, the state has a compelling interest in protecting and promoting public health and, here, in adopting measures reasonably designed to prevent the spread of AIDS." *Adams*, 149 Ill.2d at 343. Further, "[t]he HIV testing statute is designed to serve a public health goal, rather than the ordinary needs of law enforcement. *Id*. at 343-44. The court concluded that once persons who are carriers of the virus have been identified, the victims of their conduct and the offenders themselves can receive necessary treatment, and, moreover, can adjust their conduct so that other members of the public do not also become exposed to HIV. In this way, the spread of AIDS through the community at large could be slowed, if not halted. *Id*. at 344. Thus, the court held that the HIV testing requirement advanced a special

governmental need.

The court then balanced the state's interest against the intrusion on personal freedom. The court held that the actual physical intrusion required by the HIV testing statute was relatively slight, was a routine test performed over the course of an individual's life, and posed no threat to the health or safety of the individual tested. Thus, the court held that "in view of this important public health mission, we consider that the state's interest in conducting suspicionless testing outweighs the individual's interest in requiring some degree of individualized suspicion." *Id*. at 346.

While *People v. Adams* dealt with mandated testing in a criminal, not civil, context, the language the Illinois Supreme Court used to justify the testing seems particularly relevant today in light of the COVID-19 crisis. The COVID-19 virus itself is easily transmitted, yet determining who has been infected has proved to be difficult as symptoms, and severity thereof, vary from individual to individual. Yet this virus has resulted in self-isolation and "social distancing" orders in all 50 states, and the shutdown of the economy, and the offices of local, state and federal government which has not been seen since the Spanish flu epidemic in 1918. When reliable and expeditious testing, or a vaccine, becomes available, this decision, and others, provide a legal framework for the state and federal government to mandate testing and vaccination. Whether such orders will be given in such a politically-charged climate is another question, but the legal precedent certainly exists.