Conflating Capacity and Compliance

To the Editor: Patients' adherence to infectious disease control measures is a controversial issue at the intersection of medicine, public health, law, and public policy. Goldberg's recent JCP editorial[1] adeptly reviews the vital role of psychiatrists in assessing, educating, and counseling patients with varying degrees of antivaccination attitudes, but the author's call to "link vaccine refusal with capacity assessments" carries significant medicolegal implications of which practicing psychiatrists should be aware.

Goldberg's framing of vaccine refusal as a capacity issue hinges largely on the connection of fixed false beliefs about iatrogenic risks to the diagnosis of delusional disorder.[1] However, conspiracy theories and delusions are neither synonymous nor mutually exclusive. The former is more likely to arise from eccentric groupthink (often validated on the internet) than subjective experiences, whereas the content of the latter tends to be highly self-referential.[2] A multitude of aberrant behaviors and beliefs remain non-pathological, to include decisions to forgo beneficial treatment based on "epistemic mistrust" of authority.[2]

More fundamentally, evaluation of a patient's decisional capacity does not result in a permanent or wide-ranging judgment on their personal liberty. Competency determinations limiting individual rights are legal adjudications that remain the province of the courts, albeit often informed by psychiatric testimony. In contrast, decision-making capacity is a baseline requirement of medical informed consent that gauges the individual's ability to understand information about a proposed intervention and communicate a meaningful choice.[3]

Capacity must be evaluated in the context of the specific decision to be made at a particular point in time. A patient's capacity is often temporal, situational, and fluctuating. Individuals may have the ability to make some decisions, but not others, and at some junctures, but not others.[4] The goal of a clinical encounter is to maximize autonomy, not undermine it. If capacity can be optimized, it should generally be reassessed at its highest point.[5] Serious mental illness does not preclude decision-making capacity, nor by itself does involuntary hospitalization.[6]

Thus, capacity assessments are not an appropriate tool in discussions about "restricted freedoms for those who willfully pose public health hazards."[1] Goldberg's analogy of vaccine hesitancy to tuberculosis spread is inapt, as both state and federal governments have enacted robust statutory and regulatory schemes governing isolation and quarantine. Segregating infected or exposed people from the general population is a public health intervention, not a clinical one. It must be undertaken by duly constituted public health officials and is generally subject to due process as a government-sanctioned deprivation of liberty.[7]

As of this writing, COVID-19 vaccine mandates have been promulgated by the federal executive branch with respect to military service members, federal employees and contractors, employees of large businesses, and workers in most health care settings that receive Medicare or Medicaid reimbursement.[8] Many of these requirements are being challenged in active litigation. The Occupational Safety and Health Administration suspended enforcement of its large employer rule in November 2021 in light of an appellate court stoppage, then resumed it the following month (with a delay in compliance dates) when another appellate court cleared the way[9]; this split between the Fifth and Sixth Circuit Courts of Appeal will likely necessitate US Supreme Court intervention. Federal courts have also temporarily blocked the contractor vaccine mandate, as well as the health care worker mandate in certain states, while individual challenges to the military and federal employee requirements have thus far proved less successful. State-imposed mandates are subject to separate litigation, although state powers in this area are considerably more robust owing to the constitutional principle of federalism.[10] Whereas physicians can advise patients as to the potential consequences of vaccine refusal as part of their holistic care, government mandates at the federal, state, or local level are generally immaterial to the right of patients to refuse treatment at the bedside.

Fully capable individuals can possess beliefs and make choices that their physicians find wrongheaded, unreasonable, and unsalutary. Psychiatric consultations to address capacity are focused not on the soundness of patients' ideas, but on the discrete issue of whether psychopathology is directly interfering with their decision-making process. While public health crises may demand muscular government responses, the clinical realm must remain a zone of empathy and respect. Even in a pandemic, self-determination and beneficence remain the bedrocks of patient care.

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Recognizing Impaired Decisional Capacity in Vaccine Refusal: Reply to Kels and Kels

To the Editor: We thank Kels and Kels[1] for the opportunity to expound upon the relevance of decisional capacity when considering reasons for vaccine refusal. As outlined in the original editorial,[2] there are many reasons why someone might choose to refuse an FDA-approved nonexperimental lifesaving vaccine and, by doing so, put others at risk for harm. Some individuals who decline vaccination will meet Appelbaum and Grisso's criteria for capacity.[3] For instance, certain congregants of the Dutch Reformed Church acknowledge the efficacy of vaccination but question its morality, fearing that it interferes with God's will.[4] However, many vaccine objectors irrationally reject the safety or efficacy of vaccination. Such cases call into question an individual's ability to appreciate the situation and its consequences or to recognize the danger that their unvaccinated status poses to themselves and others. It is the purview of psychiatry to recognize when mental processes that influence decision-making are impaired. A consistent inability to synthesize factual information or to recalibrate one's choices in the face of correctable falsehoods (eg, "vaccine misinformation") is fundamentally distinct from an "epistemic mistrust of authority." Indeed, the *DSM-5* defines delusions as "fixed beliefs that are not amenable to change in light of conflicting evidence."[5] Magical thinking in the face of dire stresses may be psychologically protective (eg, coping with grief or a grim diagnosis), but abject denial of reality can undermine decisional capacity—as when patients unreasonably and desperately embrace unproven COVID-19 "remedies" (such as ivermectin) despite a surfeit of negative scientific evidence.[6]

As the Kels note, the preservation of autonomy assures that people remain free to make terrible health care decisions without necessarily calling into question their decisional capacity, such as choosing to smoke cigarettes or ignore diabetic diets. Adverse health consequences from such bad decisions usually directly affect only the individual. Persons with capacity may also make choices that have deleterious health care consequences for others, such as refusing treatment for tuberculosis or driving while intoxicated; however, these individuals become subject to the police power of the state and often criminal sanction. At the extreme, an individual meeting criteria for sociopathy might indifferently or even intentionally seek to spread an infectious disease such as AIDS or COVID-19 while fully understanding the consequences of his actions[7]; while doing so is clearly unethical and likely illegal, it does not implicate questions of decisional capacity. In addition, the law often allows individuals who do not meet the formal standards of capacity to render their own medical decisions when doing so is consistent with a long-standing religious or cultural practice. For example, Christian Scientists generally do not have their medical decisions overridden, although they cling to beliefs highly inconsistent with the scientific underpinnings of allopathic medicine (eg, that antibiotics do not cure bacterial infections). That latitude is afforded to Christian Scientists, or similar groups, not because they possess decisional capacity but, rather, because our society has rendered a cost-benefit analysis that favors autonomy over intervention for certain groups, *even in the absence of capacity*, when the consequences fall entirely upon themselves.

What is distinctive about vaccine refusal vis-à-vis decisional capacity is that refusers both pose a danger to *others* and simultaneously fail to appreciate this danger due to fixed, false beliefs. These dangers may prove immediate, such as when a vaccine-refusing inpatient is discharged to a nursing home, where they run the risk of infecting other residents, or more long term, such as when vaccine refusal promotes further viral mutations and needlessly prolongs the pandemic and drives societal morbidity and mortality. If a single individual believed that vaccines caused human beings to become magnetic or contained microchips that tracked and controlled him, psychiatrists would have no difficulty in declaring that individual too psychiatrically impaired to render decisions related to vaccination. That other individuals share these paranoid, delusional beliefs do not render them any less pathological.

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