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Covert medication – ever ethically justifiable?

'The practice of psychiatry is more vulnerable to criticism than any other area of medicine' (Mason & McCall Smith, 1999). The interventionist philosophy of psychiatry and the legacy of the psychiatric practices of the past century have left an imprint on society's mind of coercive treatments against a background of unscientific evidence of benefit. Other medical specialities conversely are forgiven their history of barbarism (has anyone been to a medical museum lately?) on the grounds that they were using the only tools available to them at the time. Public attitudes, including stigma and suspicion, make it more difficult for us to claim a similar defence, and modern day psychiatrists appear to bear the indelible scars of our predecessors' actions.

Within this atmosphere of latent public mistrust, coupled with a perception of paternalistic fervour, we have increasingly recognised a need to scrutinise and banish from our institutions many practices deemed incompatible with the liberal individualistic society in which we live. Equally, successive Mental Health Acts, most notably the 1959 and 1983 Acts, have sought to allay the fears of civil liberties groups, albeit with limited success.

Covert medication, however, sounds like a coercive remnant from our disreputable past, a reminder that institutional practices are still alive and well in the 21st century.

There is little systematic research to establish how widespread the use of covert medication actually is. A recent paper by Treloar *et al* (2000) confirms our own informal enquiries, which detail a course of action that is relatively widespread yet formally prohibited in all but the most exceptional circumstances. Such decisions are being made unilaterally in some instances, in others without discussion with relatives, doctors or, perhaps more worryingly, pharmacists. The fear of professional censure (Kellett, 1996) may ensure that it is a subject discussed little, with the result that minimal recording takes place in patient notes or care plans, compounding the atmosphere of secrecy and suspicion. Does this current system, however morally unsatisfactory, act as a self-regulatory mechanism to ensure that all other routes of therapeutic intervention have been exhausted before employing such draconian measures? Or is the converse true, where the lack of any objective supervisory or

regulatory processes leaves vulnerable patients open to exploitation and abuse?

This paper does not seek to approve or disapprove the use of covert medication, rather to identify relevant legal and ethical perspectives. As with many complex ethical issues in law and medicine, there are no absolutes and no comfortable reductionist principle that will suit every situation.

Ethical background

There exists a fundamental ethical and legal obligation in medicine to respect autonomous decision-making. The issue of covert administration of medication given to an autonomous individual against his/her will is, both legally and ethically, entirely unacceptable. Where doubt exists would be in a situation relating to non-autonomous individuals who, through incapacity, are rendered unable to give informed consent to receive or refuse medication *per se*. If medication is prescribed under 'best interests' principles, is there any difference (ethically) between a patient passively accepting medication and having it disguised in some way following refusal? Is all medication, however administered, 'covert' in reality if the individual is not capable of giving informed consent?

Can the practice of disguising a person's medication such that he or she is unaware of its administration ever be justifiable by appeal to principles of beneficence and non-maleficence in incapacitated patients, or to concepts of least restrictive to person's freedom and action? What benefits versus harm could result from the 'tablet in jam' scenario?

One way of approaching the problem is through a casuistic perspective. Consider an adult with learning disability who consistently rejects all oral medication, including anticonvulsants. Nursing staff, in cognisance of the prohibition of covert medication, administer such essential medication by suppository on a daily basis. Consider another elderly patient with cognitive impairment who is clearly acutely disturbed and represents a significant risk of harm to him-/herself or to others. Could benefit outweigh harm if the practice of covertly administering anticonvulsant and sedative drugs, respectively, is in fact judged to be the least restrictive measure to maximise each patient's liberty and dignity (i.e. less



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than that accorded by suppository, or restraint followed by intramuscular injection)? Which is more, or less, acceptable in a young healthy adult with incapacity versus a frail elderly person? Should that matter and is the question ethically specific to individual circumstance or subject to generalisation?

Arguably, in residential settings, tranquillising medication might be seen as a cheap means of managing inadequate staffing levels (and thus ensuring a quiet shift), or an essential (and least restrictive?) means of managing unpredictable, violent outbursts against staff and fellow patients.

Also, although few would dispute the moral duty to administer anticonvulsant medication, or essential cardiorespiratory treatments or even insulin, should the behavioural management of the consequences of dementia and learning disabilities be included in the same category of 'necessity'? (Department of Health & Welsh Office, 1999). Carers of those with dementia did not differentiate a moral difference between medication for psychiatric disorder and that for physical disorder (Treloar *et al*, 2000), nor did professionals (Treloar *et al*, 2001).

Is there, nevertheless, a case for a continuum of acceptability of mode of administration in all treatment proposals, just as there is a continuum of levels of capacity required for particular treatment measures ('a capacity . . . commensurate with the gravity of the situation')? (*Re MB*, 1997). For example, should we set a lower threshold for the use of covert anticonvulsants for epilepsy than covert tranquillisation for behaviour disturbance (which also might be amenable to psychological interventions)?

Should accepted oral medication trump suppository, which trumps injectable, which in turn trumps covert administration, or should the order be different, and, more importantly, what is the individual patient most likely to have wanted (by a process of substituted judgement) and what would his/her family want for him/her? What would they do in the same set of circumstances if the situation arose in the home? Would they adhere to our intransigent rules against disguising their loved one's medicines, or seek what might be perceived as the path of least resistance, with the best of moral intention?

Instead of complex debate, can we forget the above and seek refuge in deontological principles, which focus on the rightness or wrongness of acts by deciding that if treatment is right, does it truly matter *how* it is given, in coffee or tea or jam or undisguised on a spoon? Or is all covert medication deontologically wrong? Are we taking refuge under the utilitarian perspective of ends justifying means, of maximisation of happiness, of greatest good for the greatest numbers, or is that a comforting smokescreen?

Finally, if covert medication contravenes contemporary ethical practice, can it ever be made ethical by the inclusion of additional safeguards?

As with many uncertainties in medicine, we often look to the law to guide us through such conflicting moral imperatives, and case law can, in certain circumstances, serve to highlight and clarify the legal position in similar issues presented to the judiciary.

Legal considerations

Legally, treatment without consent is permissible only where common law or statute provides such authority. Treatment for those who refuse treatment yet who retain capacity can be authorised by statute under Part 5 of the Mental Health Act 1983, whereas treatment for those who lack capacity may be prescribed in their best interests under the common law doctrine of necessity, and thus necessary to save life or prevent deterioration or ensure an improvement in the patient's physical or mental health (Department of Health & Welsh Office, 1999).

Case law has served to define the breadth of the duty owed by, and power accorded to, professionals who treat patients who lack capacity. 'In many cases . . . it will not only be lawful for doctors on the ground of necessity to operate on, or give other medical treatment to adult patients disabled from giving their consent: it will be their common law duty to do so.' (*F v West Berkshire Health Authority and Another*, 1989) In addition, 'Reasonable force can be used to ensure that the patient accepts treatment. There must be a necessity to act and the action taken must be such as a reasonable person would in all the circumstances take, acting in the best interests of the patient.' (*Norfolk and Norwich Healthcare NHS Trust v W*, 1996) 'The extent of force or compulsion that may become necessary can only be judged in each individual case, and by health professionals. It may become for them a balance between continuing treatment which is forcibly opposed and deciding not to continue with it.' (*Re MB*, 1997)

The law in relation to the mentally ill clearly states that, 'The detention of a compliant mentally incapable informal patient is authorised under the common law doctrine of necessity.' (Jones, 1999) Furthermore, if the patient is not exhibiting dissent to being in hospital, the law confirms that the provision of medical treatment (for a physical or psychiatric disorder) is authorised under common law in the patient's 'best interest'. It also specifies 'the *sectioning* of the patient for the purpose of providing *authority* for medical treatment for his mental disorder to be given is unnecessary. Such an action is almost certainly unlawful . . .' (Jones, 1999)

This reflects the recent House of Lords judgement in *R v Bournewood Community NHS Trust ex parte L* (1998), which overturned an earlier Court of Appeal ruling in confirming that a compliant incapacitated patient does not require the formal powers of the Mental Health Act 1983, admission and treatment of mental disorder being based on the common law principles of necessity. The case, which involved a man with autism, initially led the Appeal Court to state 'The right of a hospital to detain a patient for treatment for mental disorder is to be found in, and only in, the 1983 Act, whose provisions apply to the exclusion of common law principles of necessity.' (*L v Bournewood Community Mental Health NHS Trust*, 1997)

This begs the question of the difference, ethically and legally, between compliant incapacitated patients suffering from a mental disorder and non-compliant incapacitated patients? Legally, within mental health, there seems to be some conflict, with the former treated



informally and the latter formally under Mental Health Act guidelines, but ethically is this a false boundary? (Even the wording of such guidance (above) serves to promote confusion – *detention* used in the same context as *informal*. How can you detain informal patients?) By natural progression from the above, would the compulsory detention, and treatment thereafter, of any patient being given covert medication afford them the protection of independent scrutiny by the Mental Health Act Commission, and, in reality, how many more in-patient beds would be needed to cope with this extra demand?

Many of the current dilemmas in this area have come to public attention possibly because of two important developments in medical ethics and the law, respectively – the increasing importance accorded to respect for autonomy and loss of the *parens patriae* jurisdiction of the courts. The latter, literally ‘parent of the country’, permitted a court to consent or refuse treatment on behalf of an ‘incapax’, or alternatively to appoint a guardian with such powers (Mason & McCall Smith, 1999). It was held initially by the monarch and later vested in the High Court by the Sign Manual. Parallel jurisdictions in Australia, Canada, Ireland and the USA adopted such authority from English Law, and Scotland had its own tutor dative. Revocation of the Sign Manual and implementation of the 1959 Mental Health Act extinguished such power in England and Wales, but examples of its usage remain evident in common law judgements in Canada, Australia and Ireland (Mason & McCall Smith, 1999).

Nevertheless, court paternalism has as much to recommend it as medical paternalism and many jurisdictions have opted for forms of proxy/surrogate decision-making. The USA has set three standards in order of preference: the subjective test (based on wishes actually expressed while competent); substituted judgement (based on what the patient would have wanted); and best interests as a ‘last resort’ (Mason & McCall Smith, 1999).

With respect to the specific circumstance of covert (involuntary) administration of medication to an otherwise compliant (and therefore voluntary) patient, the authors have extensively reviewed the literature pertaining to other jurisdictions and have been unable to identify a comparable situation elsewhere. We conclude that the principles/court powers above would apply. Creation of a durable power of attorney in the USA allows another to make limited treatment decisions, but it is noteworthy that in some US jurisdictions even involuntary patients cannot be given medication involuntarily without the consent of a court or designated guardian (Wettstein & Roth, 1988). A Gerontology Working Group in Germany also confirms support for proxy consent by a legally authorised representative in drug treatments for incompetent subjects (Wolf, 1996).

Future legislative change?

Against a background of uncertainty and murmurings of dissatisfaction among legal commentators in this country

(who perceive the medical profession as capable of declaring incompetent anyone who disagrees with them – ‘refusal, not as an assertion of will, rather as a symptom of unsoundness of mind’ (Grubb, 1994)), recent Law Commission proposals might serve to clarify our professional responsibilities and practices. Their draft ‘Mental Incapacity’ bill recommends, ‘statutory provision should be made to the effect that decisions made by others on behalf of people without capacity must be made in the best interests of the people without capacity’ (Law Commission, 1995). In *Making Decisions* (Lord High Chancellor, 1999), the Lord High Chancellor accepted the Law Commission proposals for guidance on how best interests should be determined, including the following factors for consideration:

- (a) ‘Ascertainable past and present wishes and feelings of the person.’
- (b) ‘The need to permit and encourage the person to participate or improve his or her ability to participate as fully as possible in anything done for and any decision affecting him or her.’
- (c) ‘The views of other people whom it is appropriate and practical to consult about the person’s wishes and feelings and what would be in his or her best interests.’
- (d) ‘Whether the purpose for which any action or decision is required can be as effectively achieved in a manner less restrictive of the person’s freedom of action.’

There is a further reference to such factors not being ‘applied too rigidly, and should not exclude consideration of any relevant factor in a particular case’ (Lord High Chancellor, 1999).

Such proposals, albeit in altered format, are currently being implemented in Scotland via the Adults with Incapacity (Scotland) Act 2000 (HMSO, 2000) which received Royal Assent on 9 May 2000. Safeguards relating to discussion of treatment proposals with, and approval by, nearest relative and primary carer, and, if applicable, the adult’s ‘guardian, welfare attorney or person authorised under the intervention order (with power in relation to any medical treatment)’ form a core part of the statute, as do guidelines on prescribed ‘certification’ as to incapacity, and time limits imposed for aforesaid treatment, with a judicial appeal process in the event of disagreements between professional and other interested parties (HMSO, 2000).

Clearly the law is entering a phase of change in seeking to redress the legal inconsistencies (and blatant disregard?) afforded by the judiciary towards those who lack capacity, an ‘indefensible gap’ that leaves many incapacitated patients at present without the safeguards enshrined in the Mental Health Act 1983.

Conclusion

In the light of impending legislative developments, decision-making about what constitute ‘best interests’ will not remain the sole or necessarily ultimate preserve of the profession (although ‘good practice’ already demands the involvement of all interested parties



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involved in the care of vulnerable patients or residents) and psychiatrists must be prepared to open up their practices to societal and, if necessary, judicial scrutiny.

This appears to be happening already, with the Royal College of Psychiatrists (Old Age Sub-section) setting up a recent meeting (January 2001) on the subject of 'concealed medication'. A series of presentations were debated and members present unreservedly approved proposals to set up a Working Party to debate the issue and consider guidelines for best practice, in conjunction with representatives of other professions including social workers, general practitioners, pharmacists, nurses and possibly lawyers. We agree that such guidelines must necessarily be practical in their application, 'without unnecessary obstruction by cumbersome legal processes' (Treloar *et al*, 2001).

The preliminary findings of Treloar *et al* (2000), although small in number, represent an early indication of the support of carers in the use of covert medication for incapacitated adults in exceptional circumstances. In conjunction with new statutory proposals and professional debate, a more open and honest approach seems possible, with implicit benefit for all concerned. In a situation where conflicting values between freedom and protection and liberty and paternalism collide, and the basic human rights of the most vulnerable members of our society are at stake, we must ensure that the sanctioning of such activities in certain prescribed situations does not herald a return to the dark ages of psychiatry, notwithstanding the defence of beneficent purpose.

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