

CLINICAL ETHICS

"I can put the medicine in his soup, Doctor!"

J G W S Wong, Y Poon, E C Hui

J Med Ethics 2005;31:262–265. doi: 10.1136/jme.2003.007336

The practice of covertly administering medication is controversial. Although condemned by some as overly paternalistic, others have suggested that it may be acceptable if patients have permanent mental incapacity and refuse needed treatment. Ethical, legal, and clinical considerations become more complex when the mental incapacity is temporary and when the medication actually serves to restore autonomy. We discuss these issues in the context of a young man with schizophrenia. His mother had been giving him antipsychotic medication covertly in his soup. Should the doctor continue to provide a prescription, thus allowing this to continue? We discuss this case based on the "four principles" ethical framework, addressing the conflict between autonomy and beneficence/non-maleficence, the role of antipsychotics as an autonomy restoring agent, truth telling and the balance between individual versus family autonomy.

Covert administration of medication to an adult patient—for example, concealing the medication in a patient's food or drinks without his or her knowledge, is controversial. Commentators who condemn covert administration of medication argue that it is overly paternalistic and deprives the patient of the right to make health care decisions as well as his/her right to be told the truth.¹ In mentally capable patients, it is clearly a breach of autonomy and thus unacceptable.² In patients who may be mentally incapacitated permanently or temporarily, the debate is centred on whether the best interest of the patient is a sufficient ethical justification for the practice. Concern has also been raised that even if this practice may be condoned in a few exceptional cases, such as in an emergency, any general acceptance of such a practice may give rise to abuse.³ Specifically, it may become an "easy excuse" for not discussing and explaining treatment to patients or their families, and may also reinforce tolerance of poor staffing levels or poor standards in patient care settings. These risks are amplified when the practice remains unregulated and unmonitored because of a lack of legal or professional guidelines, and of the secrecy surrounding the practice due to fear of professional censure.⁴

On the other hand, some commentators suggest that concealing medication can be ethically acceptable for mentally incapacitated patients in some circumstances. The UK Central Council for Nursing Midwifery and Health Visiting (UKCC) has, for example, issued guidance to nurses⁵ stating that "disguising medication in food or drink can be justified in the best interests of patients who actively refuse medication but who lack the capacity to refuse treatment". Covert medication "may be considered to prevent a patient from missing out on essential treatment where the patient is incapable of informed consent". The guidelines emphasise that such action should be taken only as a contingency measure in an emergency, and after discussion with the

clinical team and the patient's carers. Treloar *et al*⁶ argue in favour of giving needed treatments to patients without capacity to accept or refuse treatment, regardless of whether the treatment is routine or emergency. They believe the harm of "deceiving" a mentally incapable individual by concealing medication would be outweighed by the harm of depriving the patient of needed treatment, especially if covert administration of medication represents the least distressing or least restrictive method of giving treatment. These writers base their views on their empirical study⁶ on inpatient and community units caring for patients with dementia. Their study reveals that the practice of giving covert medication is widespread in the UK, occurring in 71% of long stay care units. Ninety six per cent of community carers considered covert administration of medication, for both physical and mental disorders, as justifiable in certain circumstances—for example, if it were the only way to administer needed treatment.

Many previous works on covert medication administration have focused on people with long term mental incapacity—for example, dementia or intellectual disabilities. As patients with dementia have previously been mentally capable it is worthwhile to examine their previously expressed wishes about the proposed medication or about covert medication. Otherwise, the discussion in dementia and intellectual disabilities groups surrounds whether covert administration of medication is necessary in the best interests of the patients. Patients with fluctuating or temporary mental incapacity provide a greater challenge because whether we need to respect their wishes or make decisions on their behalf based on their best interests would vary according to their mental capacity at the relevant time. We report a case in Hong Kong in which a mother gives antipsychotics mixed in soup to her son with schizophrenia. The case raises important ethical and legal issues. We discuss, based on the framework of the "four principles of biomedical ethics" as proposed by Beauchamp & Childress,⁷ (1) the conflict between the principle of autonomy and the principles of beneficence and non-maleficence; (2) the special considerations of the use of antipsychotic medication that restores mental competence and autonomy; (3) maintaining a balance between family autonomy and individual autonomy, and (4) upholding the principle of truth telling, which is based on respect for autonomy.

CASE HISTORY

Y is a 25 year old unemployed man with a two year history of paranoid schizophrenia. He lives with his parents and a younger sister. During previous psychotic episodes, he had persecutory delusions that his mother wanted to harm him, with a history of violence against her. He had three previous brief hospitalisations. Despite his excellent response to antipsychotics, his insight into his illness was poor. Discussions with his psychiatrist, Dr W, about the nature of his illness and the need for maintenance antipsychotic treatment often elicited angry and defiant responses from Y. His adherence to medication regimens and follow up visits

had, however, been mostly satisfactory because of supervision and support from his very caring mother, who accompanied him to his psychiatric follow up sessions every time.

One day, Y's mother came to the clinic alone, and told Dr W that Y refused to take the antipsychotics and to come for follow up. He had thrown away all his medication 3 weeks earlier and as a result had become actively psychotic again. He had accused his mother of persecuting him, and had become very hostile toward her. He had also heard voices talking about him in an abusive way. The mother asked Dr W for her son's regular antipsychotics so that she could encourage him to take them. Since the mother had always been the main carer actively involved in Y's psychiatric care, and bearing in mind the threat of violence to her, a prescription was given to her, together with advice on emergency measures should Y's condition deteriorate further. After this encounter, Dr W went on maternity leave.

When Dr W returned to work, she saw the mother alone in the clinic again, at a time when Y was scheduled to come back for a follow up visit. The mother described what had happened since they last met. She had failed to persuade Y to take the antipsychotics, or to attend for psychiatric follow up. In desperation, she had started to mix Y's medication covertly in his soup. This had had a good effect. He had got better and was no longer psychotic and hostile to her. Relieving doctors had continued to supply prescriptions for the mother during the 3 months that Dr W was away, making notes on Y's records stating: "medication supervised by mother". It was unclear whether the relieving doctors were aware that the medication was being concealed in Y's soup. The mother was very happy with the current arrangement. "Doctor, just give me the prescription and I can put the medicine in his soup."

DISCUSSION

Conflict between the principles of autonomy and beneficence/non-maleficence

The pressing issue for Dr W is whether she should continue to provide Y's mother with the prescription: this is not a simple question with a "Yes" or "No" answer. All efforts should be made to persuade Y to engage with the mental health services so he can be assessed clinically. It is important to talk to Y's mother and other family members about the potential risks, the relevant ethical and legal issues of covert medication administration, and the necessity of seeing the patient for clinical assessment. In this case, however, despite all efforts, Y refused to see any mental health professional and his mother continued to ask for a prescription for antipsychotic medication so that she could carry on giving it to Y in his soup.

It may be argued that because Y was acutely psychotic he was mentally incapable of making a decision about his treatment, and so giving him treatment without his consent was justified. The principle of autonomy was not violated, and the act was consistent with conventional judicial tradition. In Hong Kong, any medical and dental treatment of mentally incapacitated adults is legally governed by the common law and the Mental Health Ordinance,⁸ which states that the legal guardian of a mentally incapacitated adult may be given the power to consent to treatment. If no guardian is appointed, the medical practitioners in charge are given the power to give both urgent and non-urgent treatments to the mentally incapacitated adult without his consent, provided that the treatment is given in his best interests. The "best interests" clause is clearly intended to uphold the principle of beneficence and non-maleficence.

Even if it was morally justified to give Y medication without consent, however, the way in which medication was given might become a subject of debate. Can the moral justification be extended to include deceiving the patient? If

the answer is negative, it implies that giving treatment to a mentally incompetent patient such as Y should only be done openly albeit by force. While this would preserve the principle of veracity, it is dubious whether administering medication to a mentally incompetent patient by force is practical or wise. In the case at hand, we should bear in mind Y's strong resistance to taking treatment, as well as his paranoid beliefs of, and violence toward, his mother. Legal provisions state that consideration should be given to the administration of treatment to a mentally incompetent individual in the least restrictive way.⁴ It can therefore be argued that concealing medication in a mentally incompetent patient's food or drink may be justified on this basis, and considered as an act of "weak paternalism".

Considerations about continuing to provide prescriptions for the mother after the patient has recovered from his acute psychotic episode pose far greater challenges. If we assume that Y is mentally capable in his remission, (although a formal assessment has not been made), concealing medication in Y's food would constitute an act of "strong paternalism", in which an autonomous person's wishes are overridden on the basis of the principles of beneficence and non-maleficence. It would be an outright act of deception which in itself is a harm to the patient. Legally, such an act may be considered an assault or battery since treatment is given without a mentally capable patient's consent.

One option is to stop providing the prescription for the mother, thus stopping treatment. The discontinuation of treatment may "induce" a relapse, then antipsychotics can be started again under formal procedures—for example, compulsory admission. This would "break the cycle of deception". The question is whether an acute relapse is a reasonable price to pay for our pursuit of honesty. A relapse of schizophrenia can lead to many adverse effects. The immediate ones are more obvious—for example, deterioration in mental state, risk of harm to self or others. Moreover, the detrimental effects of untreated psychosis on the long term prognosis of schizophrenia should not be overlooked. It has been shown that the longer a schizophrenic patient is psychotic, especially in the first few years of the illness, the worse the long term outcome.⁹ Thus, intentionally discontinuing treatment to break the cycle of deception with a foreseeable consequence of a relapse causes harm to the patient and violates the principle of non-maleficence.

Antipsychotics as an autonomy restoring agent

Let us assume we accept the argument that acts of weak paternalism are justified but not acts of strong paternalism. Since the covertly administered antipsychotic is an "autonomy restoring" agent, it is possible to see the covert administration of anti psychotic medication as an act shifting back and forth between weak and strong paternalism, depending on the patient's mental capacity. Ideally, when Y regains mental capacity after receiving covert medication during his temporary incapacitation, the doctor then employs other means to persuade him to take medication to prevent future relapses. If, however, Dr W has no other means to ensure compliance when Y is competent, we argue that to discontinue covert medication when that is the only available means to provide treatment not only violates the principles of beneficence and non-maleficence, but also Y's autonomy. In other words, not only is Y harmed by the relapse of schizophrenia because of not receiving medication, he also loses his autonomy during the consequent "relapse". It is ironic that Y regains his autonomy through covert medication, and in turn the autonomy so gained disallows the very medication covertly given, and he loses his autonomy again in the process. If we withhold covert medication and wait till Y becomes incompetent again before we resume covert

medication, it is dubious whether the repetition of covert medication can any longer be considered an act of “weak paternalism”. For, if before the relapse occurs, the competent patient explicitly indicates his refusal of antipsychotic medication, this may constitute a valid advance directive, so that to provide it when he is in relapse and becomes incompetent is nothing less than an act of “strong paternalism.”

Balancing family and individual autonomy

Many of our considerations so far involve a weighing of different clinical factors as applied to Y as an individual. There should, however, also be a weighing of family rights against individual rights. In Chinese culture, the notion of respect for an individual’s right to self determination is a weak notion due to the Confucian concept of social personhood.¹⁰ Family input in treatment decision making in Chinese cultures is not only common and considered the norm, it is often decisive. While Western medical ethics tends to focus on the individual, this approach has been recognised as being limited, thus increasing attention has been put on social relationships and seeing each person within his or her social context. Many argue that family relationships and family interests should play a role in patient decision making,^{11 12} but there is no consensus as to the extent to which family interests should count.¹³

A justification for continuing treatment of the patient with covert medication can be found in society’s moral obligation to protect family interests and to preserve family autonomy. If the patient belongs to a family, then the interests of each member of the family are interconnected, and there should be mutual respect for each other’s autonomy. The case history of the patient clearly indicates that the condition of the patient profoundly impacts on the welfare and safety of other family members living with him, and particularly on his mother. The act of discontinuing covert medication is intended to respect the patient’s autonomy, but if such an act carries the potential risk of precipitating a relapse whereby, not only may the patient lose his capacity for decision making, but also the autonomy of other family members may be violated, then the moral validity of the act should be questioned. Greater harmony between the interests and autonomy of the patient and those of the other family members must be achieved. In English speaking countries in the West, the trend is to emphasise the importance of protecting patient autonomy because it is believed that a sick person is less able to protect his or her own interests and more vulnerable to exploitation by family members. This may well be true in some cases, and therefore individual autonomy is generally allowed to trump family autonomy, but one has to be cautious about a course of action that entails a disproportionate sacrifice of family interests in order to protect patient autonomy. In these cases, family interests and family autonomy should be factored into the patient’s treatment plans. In the case at hand, this may mean the continuation of covert medication until other measures are put in place—for example, patient education—to enable the patient to take medication voluntarily. In this connection, it should be added that the doctor and other providers are in a unique position to play a crucial role in maintaining harmony between patient and family interests, and in ensuring that the autonomy of both parties is protected.

Truth telling and autonomy

Should Y be told, at any stage, about his mother giving him medication in his soup? Obligations of truth telling are usually justified on the basis of the principle of respect for autonomy, obligations of fidelity, and the relationship of trust that is inherent in any interactions between doctor and

patient. Telling patients the truth goes beyond simple information disclosure for the purpose of making treatment decisions; it includes a broader definition, encompassing the accurate and honest communication of information.¹⁴ Like other obligations, however, truth telling is *prima facie* binding, but not absolute. There may be situations in which truth telling and respect for autonomy may be overridden by beneficence/non-maleficence—for example, in cases described as “benevolent deception” (Beauchamp TL,⁷ p 339) when telling the truth may produce great harm¹⁵ or when not telling the patient the truth (or the whole truth) is clearly in the patient’s best interests.¹⁶ We believe that the situation in our case falls within such a category. If Y’s mother’s actions were disclosed to him, the relationships of trust between mother and son, and between doctor and patient, would be likely to break down. The patient would resent being deceived in this way and would become angry and feel betrayed. His persecutory beliefs may become more fixed and he would probably develop an even more negative attitude toward mental health services and become even more hostile toward his mother, thus undermining the most reliable support he has. The possibility that the patient will disengage himself completely from medical care is a real one, with predictably disastrous results. Furthermore, the benefits of disclosure are not very compelling. Clearly it would be respectful of Y’s autonomy, and telling the truth may also facilitate efforts at education about the value of antipsychotic treatment. This presupposes, however, that the patient will react to the truth (of having been covertly medicated) with reason and docility, a scenario in which we have little confidence. Hence, we believe that until the patient is enlightened to his own need of medication, on balance the harm of truthful disclosure exceeds benefit.

CONCLUSION

This case of covert medication highlights ethical, clinical, and legal dilemmas in the management of patients with schizophrenia with poor insight. By adhering to the “four principles” ethical framework, we conclude that whether covert medication is ethically and legally justified depends on a rather delicate and risky balancing act between the respect for autonomy, and the principles of beneficence and non-maleficence. In individual cases, the type of medication given; the extent of the need for the medication; the person who administers the drug; the purpose of covert administration, and whether there are any less restrictive alternatives, are all factors to consider.

Dr W has been placed in a very difficult dilemma in which neither of the obvious options (stopping the prescription or continuing with the prescription) seems intuitively right. Continuing the prescription would keep Y well and keep the mother safe, but this would be at the expense of Y’s right to self determination. It would also expose the doctor to potentially serious legal liabilities because Dr W is writing a prescription for a patient without seeing him. If Dr W can persuade Y to see a mental health professional—for example, a community psychiatric nurse, at least Dr W can provide a prescription based on the reports of a professional colleague. Dr W can also obtain further endorsement for her course of action by consulting with senior colleagues and members of the multidisciplinary team. Whether and to what extent these absolve her of her legal liabilities remains unclear, but it would certainly be preferable to prescribing merely based on the mother’s report. Furthermore, Y is probably mentally capable of making a decision about his treatment now, and therefore consent from him is required. Stopping the prescription has major implications for Y’s mental health and for his mother’s safety, however, especially when Y is not under the surveillance of any mental health professional. This

course of action may potentially lead to a serious adverse outcome, and thus would act against the principle of non-maleficence.

One of Dr W's major difficulties was not being able to see and talk to Y directly in order to assess his mental condition and to impress upon him the values of maintenance antipsychotics. If only Dr W can talk to Y, there is room for discussion and education, and these may provide options other than the two extreme options described above. A coincidence helped in the resolution of this case. Dr W received documents from the Social Welfare Department, stating that Y's disability allowance needed to be renewed. This provided a good reason to invite Y back to the clinic for an assessment of his level of disability. Since Y was keen to continue to receive financial assistance, he willingly returned to the psychiatric clinic. Y was assessed to be clinically free of psychotic symptoms and was found to be mentally capable of making treatment decisions. A long period of discussion and education ensued, after which Y finally agreed to accept psychiatric follow up and medication. By having discussions about treatment and about financial assistance in the same session, Dr W was mindful that it could be perceived as coercive. Although she avoided making any direct links between Y's adherence to treatment and his continuing to receive financial assistance, the extent to which Y still felt pressure to comply remains unclear. Dr W did not disclose to Y that his mother had been concealing medication in his soup.

One main concern about covert medication is the lack of definite guidelines and policies regulating this practice, leading to fear of litigation¹⁷ and hence secrecy surrounding this practice. The problem of secrecy in turn makes regulation even more difficult and hence increases the risk of abuse.⁵ Having said that, this case describes the attempts made by a loving mother to prevent her son from having a psychotic relapse; there was no malice or intention to abuse. The good intentions of the mother make this case more difficult to resolve. The ethical, legal, and clinical issues surrounding covert medication are complex and, if possible, guidelines should be provided to the medical professionals and the carers of mentally incapacitated adults about how to respond when covert medication is considered or proposed.

Authors' affiliations

J G W S Wong, Department of Psychiatry, Faculty of Medicine, The University of Hong Kong, Hong Kong

Y Poon, Queen Mary Hospital, Pokfulam, Hong Kong

E C Hui, Faculty of Medicine, The University of Hong Kong, Hong Kong

Disclaimer: An earlier draft of this paper was presented at the 28th International Congress on Law and Mental Health, Sydney, Australia, October 2003.

The work should be attributed to: Faculty of Medicine, the University of Hong Kong

Correspondence to: Dr J G W S Wong, Department of Psychiatry, The University of Hong Kong, Queen Mary Hospital, 102 Pokfulam Road, Hong Kong; jgswong@hku.hk

Accepted for publication 2 March 2004

REFERENCES

- 1 **Honkanen L**. Point-counterpoint: is it ethical to give drugs to people with dementia? No: covert medication is paternalistic. *West J Med* 2001;**174**:229.
- 2 **Kennedy I**, Grubb A. *Medical law*. London: Butterworths, 2000:575.
- 3 **Scott J**, Williams ERL. Concealed administration of drug treatment may represent thin end of the wedge. *BMJ* 1997;**314**:299-300.
- 4 **Treloar A**, Philpot M, Beats B. Concealing medication in patients' food. *Lancet* 2001;**357**:62-4.
- 5 **Ramsay S**. UK nurses receive guidance on covert medication of patients. *Lancet* 2001;**358**:900.
- 6 **Treloar A**, Beats B, Philpot M. A pill in the sandwich: covert medication in food and drink. *J R Soc Med* 2000;**93**:408-11.
- 7 **Beauchamp TL**, Childress JF. *Principles of biomedical ethics*. New York: Oxford University Press, 1994.
- 8 **Wong JG**, Scully P. A practical guide to capacity assessment and patient consent in Hong Kong. *Hong Kong Med J* 2003;**9**:284-9.
- 9 **Harrison G**, Hopper K, Craig T, et al. Recovery from psychotic illness: a 15 and 25 year international follow up study. *Br J Psychiatry* 2001;**178**:506-17.
- 10 **Hui E**. Chinese health care ethics. In: Coward H, Ratanakul P, eds. *A crosscultural dialogue on health care ethics*. Waterloo, Ont: Wilfrid Laurier University Press, 1999:128-38.
- 11 **Hardwig J**. What about the family? *Hastings Cent Rep* 1990;**20**:5-10.
- 12 **Nelson JL**. Taking families seriously. *Hastings Cent Rep* 1992;**22**:6-12.
- 13 **Blustein J**. The family in medical decision making. *Hastings Cent Rep* 1993;**23**:6-13.
- 14 **Brody H**. The physician-patient relationship. In: Veatch RM, ed. *Medical ethics* [2nd ed]. Sudbury, MA: Jones and Bartlett Publishers, 1997:75-102.
- 15 **Kearon K**. *Medical ethics: an introduction*. Mystic, CT: Twenty Third Publications, 1995.
- 16 **Benn P**. Medicine, lies, and deceptions. *J Med Ethics* 2001;**27**:130-4.