

Covert Medication in Psychiatric Emergencies: Is It Ever Ethically Permissible?

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Covert administration of medications to patients, defined as the administration of medication to patients without their knowledge, is a practice surrounded by clinical, legal, ethics-related, and cultural controversy. Many psychiatrists would be likely to advocate that the practice of covert medication in emergency psychiatry is not clinically, ethically, or legally acceptable. This article explores whether there may be exceptions to this stance that would be ethical. We first review the standard of emergency psychiatric care. Although we could identify no published empirical studies of covert administration of medicine in emergency departments, we review the prevalence of this practice in other clinical settings. While the courts have not ruled with respect to covert medication, we discuss the evolving legal landscape of informed consent, competency, and the right to refuse treatment. We discuss dilemmas regarding the ethics involved in this practice, including the tensions among autonomy, beneficence, and duty to protect. We explore how differences between cultures regarding the value placed on individual versus family autonomy may affect perspectives with regard to this practice. We investigate how consumers view this practice and their treatment preferences during a psychiatric emergency. Finally, we discuss psychiatric advance directives and explore how these contracts may affect the debate over the practice.

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Covert medication of patients, defined as the administration of medicine to patients without their knowledge, is a practice surrounded by clinical, legal, ethics-related, and cultural controversy. Covert administration (also referred to as concealed, surreptitious, or hidden administration) of medication has not been publicly discussed until recently. In a 2002 study of patients attending an urban outpatient care center in India, it was noted that when the patients were acutely ill and refused to take medication, the families administered it to them without the patients' knowledge, under the supervision of the psychiatrist.¹ Families in half the cases of patient noncompliance had practiced this method. Many families felt that there was no viable alternative under the circumstances. Similarly, in 2005, a group of emergency physicians furthered the debate by discussing the practice of covert administration of medication in a U.S. emergency department. This most recent case

was published in an article in *Annals of Emergency Medicine* entitled, "An Unusual Case of Subterfuge in the Emergency Department: Covert Administration of Antipsychotic and Anxiolytic Medications to Control an Agitated Patient."² In this controversial report, the authors presented the following case:

A well-appearing 32-year-old man with bipolar disorder discontinued his medications 6 months before presenting to the emergency department with homicidal and suicidal ideation. He had clearly articulated a plan to murder his father and then kill himself. He walked into the ED after coaxing by his sister but would not let anyone touch him, even for vital signs. His sister said that previous violent confrontations with ED staff had left him "psychologically and physically" injured. She added that he was a respected professional but had been absent from work and on a "tremendous" spending spree and had not slept for at least 1 week. He declined medication by the ED and psychiatric staff. The emergency physician consulted with the sister, who approved a plan to have the nurse inject haloperidol and lorazepam into a sealed orange juice container and give it to the patient. The patient accepted the drink and 30 to 45 minutes later was calm and cooperative. He was admitted to the psychiatry service without further incident and discharged home 3 days later. On follow up, family (sister and parents) and patient were pleased with the outcome. All discussions with the family and rationale for the intervention were documented transparently in the medical record. Near the end of the patient's stay in the ED, the psychiatric

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consultant expressed reservation about surreptitious administration of drugs to the patient, and the nurse became concerned about potential repercussions. Three days later the psychiatry service filed an internal complaint about the conduct of the emergency physician, and risk management reviewed the case [Ref. 2, p 75].

Arguments in favor of this practice include the safety of patients and the emergency staff, clinical indications for the practice of giving medications covertly, patient and family preferences for the practice, the differences between an emergency setting and an outpatient one, and the fact that other jurisdictions outside the United States already have guidelines for the practice.² Arguments against it include violation of the patient's autonomy and procedural and substantive due process rights to be deemed incompetent to refuse treatment, the fear of worsening paranoia and adverse affects on the therapeutic alliance, concern that therapeutic insight may only be gained when treatment is transparent, the questionable legality of the practice, the possibility of side effects (some potentially severe) with a lack of informed consent or understanding by the patient regarding the likely etiology of symptoms, concern that this conduct should not be a solution to the problem of scarce resources, and the lack of transparency in the process.³

On a clinical-ethics level, is this case one of therapeutic innovation, in which the patient was treated effectively in accordance with the family's wishes and with minimal harm to staff? Or on a legal level, is the case one of criminal battery, which consists of an unpermitted, intentional act of harmful or offensive contact by another person? Many psychiatrists may argue that the practice of covert administration of medications in emergency psychiatry is not clinically, ethically, or legally acceptable.² This article explores whether there may be exceptions to this stance that are ethical. We will review several questions. What is the standard of care in an emergency situation? How common is the practice of covertly giving medication? How have the courts ruled about the practice? What are the legal and ethics-related concerns? How do consumers and families feel about the practice? Is there a role for psychiatric advance directives with respect to it?

Standard of Emergency Psychiatric Care

In 2003, Allen and colleagues⁴ published consensus guidelines for the management of agitated patients in the emergency setting. The guidelines were

based on the expert opinion of 50 U.S. emergency psychiatrists who defined the following elements: the threshold for emergency intervention, the scope of assessment for various levels of urgency and cooperation, the guiding principles in selecting interventions, and the appropriate physical and medication strategies at different levels of diagnostic confidence. Notable in the consensus guidelines was the absence of any advocacy for the practice of covert administration of medications to agitated patients.

Prevalence of Covert Medication

Despite the absence of advocacy for covert medication in the guidelines, the practice occurs in emergency departments, outpatient clinics, nursing homes, and dementia units.^{1,5,6} Furthermore, it is common in pediatrics, where informed consent from minors is not required.⁷ Our review of the literature identified no published reports of the prevalence of covert medication in emergency departments. However, three recent studies have discussed its prevalence in residential units, nursing homes, and outpatient psychiatric clinics.^{1,5,6}

In 2000, Treloar *et al.*⁶ described the practice of covert medication in 34 residential nursing care units in the United Kingdom. In this study, 71 percent of clinicians had knowledge that medications had been covertly administered to patients at their institution in food or drink. In caring for patients with dementia in the community, 96 percent of clinicians regarded the practice as justifiable for several reasons: prevention of mental distress, prevention of physical harm, risk of harm, prevention of agitation, consent of the next of kin, and maintenance of the patient's dignity. Ninety-four percent of clinicians felt that doctors should consult with caregivers before administering medications surreptitiously. Treloar *et al.* concluded that medication is often administered secretly and without discussion, probably for fear of professional retribution; that few institutions had a formal policy on the matter; and that, even if covert medication could be justified, the poor record keeping and secrecy surrounding the practice in institutions were cause for concern.

In 2005, Kirkevold and Engedal⁵ described the covert medication of 1,926 patients in nursing homes and dementia units in Norway. When clinicians were asked whether their patients had received drugs mixed in their food or beverages at least once during the past seven days, 11 percent of nursing

home clinicians and 17 percent of dementia unit clinicians reported in the affirmative. Ninety-five percent of clinicians said that the practice was routine, although it was documented in the medical record in only 60 percent of cases. The top three classes of medication covertly administered to patients were antiepileptics, antipsychotics, and anxiolytics. The top three explanatory factors for the use of this practice included the degrees of dementia, aggression, and low functioning in activities of daily living. Kirkevold and Engedal concluded that the covert administration of drugs was common in nursing homes, the routines for the practice were arbitrary, and the treatment was poorly documented in patients' records. As mentioned by Treloar *et al.* and Kirkevold and Engedal, covert medication in nursing homes and dementia units raises interesting legal implications. In the United States, several states define the inappropriate use of medications as mistreatment, which falls under elder abuse laws and mandatory reporting requirements in many jurisdictions.⁸ Given that there are both civil lawsuits and criminal prosecutions related to mistreatment, covert medication carries legal implications for providers who are found to engage in the practice.

In 2002, Srinivasan and Thara¹ surveyed 254 family members of outpatients with schizophrenia in India regarding the use of concealed antipsychotic medication in response to medication refusal by the patient. Of the 148 family members of noncompliant patients who responded, half reported giving medicines to an ill relative without the relative's knowledge. Usually, concealed medication was continued for only a few days, but in 14 percent of cases, the surreptitious treatment lasted for more than a year. In a quarter of cases, patients later found out that they had been given medicines covertly. Many of those who found out had negative reactions of anger and resentment toward the family members who gave the medicines. However, most of the patients who were given concealed medicines eventually took them openly and voluntarily.

Legal Implications

The practice of covert medication discussed in the literature raises the question of whether patients have brought legal action against practitioners for this conduct. However, a search of LexisNexis identified no U.S. legal cases to date that contain rulings on the covert administration of medication. Nonetheless,

the inappropriate use of medications can be viewed, not only as mistreatment and malpractice, but also, in the most egregious cases, as criminal battery.^{2,7} Despite the lack of U.S. legal rulings on covert medication, there is a long case history in the United States in two relevant areas: informed consent and the right to refuse treatment. Knowing how the courts have ruled in these areas, which have created the legal landscape around administration of medications, may foreshadow how courts would eventually rule on the practice of covert medication if a case were to be brought in the future.

From 1957 to 1973, landmark cases involving the evolution of informed consent, including *Salgo v. Leland Stanford University*,⁹ *Natanson v. Kline*,¹⁰ *Canterbury v. Spence*,¹¹ and *Kaimowitz v. Michigan Department of Mental Health*,¹² put forth the modern principles that adequate information must be provided for the individual to make an informed decision, the person must be competent to make the decision, and the decision must be made voluntarily. The requirements for informed consent in many states have been enacted by legislatures.¹³ Exceptions to informed consent are rare and include emergencies, therapeutic waiver, therapeutic privilege wherein the physician determines that full disclosure would be harmful to the patient, and incompetence.¹⁴ What constitutes an emergency has been defined in many states and typically includes situations in which the imposition of treatment over the person's objection is necessary for the preservation of life or the prevention of serious bodily harm to the patient or others.¹⁵

Regarding the right to refuse medications, several landmark cases, including *Superintendent of Belcherston State School v. Saikewicz*,¹⁶ *Rennie v. Klein*,¹⁷ *Rogers v. Commissioner of the Department of Mental Health*,¹⁸ *Washington v. Harper*,¹⁹ and *Sell v. United States*,²⁰ have highlighted concepts of *parens patriae*, due process rights, and least restrictive alternatives in determining a patient's competence to refuse medication. Many U.S. jurisdictions require formal adjudication of incompetence before psychiatric treatment can be administered to an incompetent patient.¹⁴ For example, the California statute, which has all the important elements of U.S. law to date, states:

If any person subject to detention, and for whom antipsychotic medications has been prescribed, orally refuses or gives other indication of refusal of treatment with that med-

ication, the medication shall be administered only when treatment staff have considered and determined that treatment alternatives to involuntary medication are unlikely to meet the needs of the patient, and upon a determination of that person's incapacity to refuse the treatment, in a hearing held for that purpose. In the case of an emergency, a person detained may be treated with antipsychotic medication over his or her objection prior to a capacity hearing, but only with antipsychotic medication that is required to treat the emergency condition, which shall be provided in the manner least restrictive to the personal liberty of the patient. It is not necessary for harm to take place or become unavoidable prior to the intervention.²¹

Two standards governing the right to refuse treatment emerged from these landmark cases, one treatment-driven (*Rennie v. Kline*¹⁷) and the other involving a substitute decision-maker (*Rogers v. Commissioner*¹⁸). Once a patient is adjudicated incompetent, decisions may be made by a judge or a guardian, usually based on a substituted-judgment standard, applying the stated or inferred preferences of the previously competent person. In some U.S. jurisdictions, standards for decision-making allow a guardian to choose treatment based on the presumed best medical interest of the patient. However, in either instance, in the United States, absent the adjudication of incompetence, psychiatric medication may be administered involuntarily only in emergencies or on an outpatient basis, in only rare circumstances.¹⁴

In the United Kingdom, the question of covert medication was addressed in the Human Rights Act of 1998.^{22,23} Several articles in the Act clearly dictate that no treatment may be given covertly that is not specifically indicated for the treatment of illness or alleviation of distress. The legislators acknowledged that for an incapacitated individual, repeated restraint and injection of treatment may be more degrading and inhumane than the covert administration of medication. To justify the invasion of privacy that covert medication entails, it must be clear that it is necessary for effective treatment. It is essential, if medications are administered secretly, that it be recorded clearly in the clinical record, so that a fair and public hearing may be obtained when required. In support of the Act, the Royal College of Psychiatrists in the United Kingdom has agreed that, in exceptional circumstances, the covert administration of medications is acceptable.²⁴

Ethics Concerns

Central ethics-related tensions in the covert medication debate revolve around patient autonomy, beneficence, nonmaleficence, and duty to protect.²⁵

Covertly medicating an autonomous individual is entirely unethical, since it clearly violates autonomy. Doubt arises in emergency and nonemergency settings when nonautonomous patients retain some measure of understanding and resist treatment. For those who lack capacity, the principle of autonomy is not violated, provided that the treatment is given in the patient's best interests. The best interests clause is clearly intended to uphold the principle of beneficence and nonmaleficence; can moral justification be extended to include deceiving the patient? In the field of medicine, the practice of prescribing a placebo (thereby deceiving the patient) has been argued to be unethical, in that the ends (i.e., the patient's sense of hope and the potential for improved outcomes) do not justify the means (i.e., deception).²⁶ What if patients (or families) deem the outcome more ethically permissible than deception? For example, consider an adult in a psychiatric emergency setting who refuses oral medication and is violent to other patients and staff. The clinical staff, recognizing the prohibition of covert medication, administers sedating medication by forced restraint and intramuscular injection each time the patient becomes agitated. Are other routes of administration more ethically acceptable? What if the patient already has an intravenous line and staff administers medication through the line without informing the agitated patient? What if the staff surreptitiously injects medication into a sealed orange juice container? Could the benefit outweigh the harm if the practice of covertly administering medication is in fact judged to be the least restrictive measure for maximizing the patient's liberty and dignity? It is legitimate to argue that for patients who require medication on a regular basis (e.g., in nursing homes), covert administration may be more ethically justifiable than in patients in an emergency setting who require medication on a one-time basis. This argument emphasizes that recurrent restraint and forced injection of medications may be more harmful clinically to patients and less humane if done frequently. Can this justification be extended to a one-time basis? What is the greater evil: unnecessary physical force or deception?²⁷

There are several examples in which the state's duty to protect its citizens overrides an individual's autonomy. With statutes ranging from mandatory reporting of infectious diseases, to laws mandating the use of seatbelts, to laws against talking on cell phones while driving, the state clearly has identified a

small but important number of circumstances in which public safety and an individual's best interests are valued over individual autonomy.²⁸ Even the various medical specialties may place different values on individual autonomy versus best interest. For example, the culture of emergency medicine may place a greater value on appropriate triage and safe placement, even if it comes at the cost of deceiving patients for the benefit of their safety or the safety of the staff.² Psychiatrists, conversely, may place a greater value on transparent disclosure, even if it comes at the cost of a patient's becoming more agitated and dangerous in an emergency setting.² For example, a paranoid patient who finds out that he has been covertly medicated might become more aggressive toward and suspicious of future clinicians. Even if the emergency department can safely triage a patient by covertly administering medication, what are the longer term consequences of such a deception? Even if there is a satisfying outcome (on behalf of the staff, family, or even the patient) in surreptitiously medicating patients, does depriving patients of the right to know what is being done to their minds and bodies nonetheless devalue their dignity? Does the end justify the means, or is it a strategy for subordinating individual values to the values of the medical team?^{29,30}

Cultural Concerns

Cultures place different values on individual and group autonomy. In a clinical case reported from Hong Kong, a young man with a diagnosis of paranoid schizophrenia was seen in an outpatient clinic with his mother.³¹ The patient had no insight into his illness and was paranoid and at times quite hostile at home. The physician prescribed antipsychotics, which the mother covertly mixed in soup and gave to her son daily over the course of several months. Is this a violation of the patient's autonomy or respect for the interests of the patient and the autonomy of the family? In Chinese culture, the notion of respect for an individual's right to self-determination is weak, because of the Confucian concept of social personhood. Family input in treatment decision-making in Chinese culture is not only common and considered the norm, but it is often decisive. Chinese culture tends to place more emphasis on the best interests of the family than on individual autonomy. Conversely, in Euro-American culture, with the emphasis on the

individual, personal autonomy generally trumps family autonomy.³¹

Srinivasan and Thara¹ made a similar argument in their study in India. They noted that the practice of covert medication by families may be culturally appropriate for India where psychiatric services are sparse and most persons with schizophrenia live with family members, who are the primary caregivers.¹ Because families give the hidden medicines on the recommendation of a psychiatrist and most medicines are administered during short periods to avert crises, the authors contended that having family members conceal medicines in this way is a viable solution to the common and difficult problem of medication refusal in other sociocultural settings as well.³²

Consumer Preferences

A central question in the debate surrounding covert medication is what do patients, as consumers of mental health care, really want? In India, Srinivasan and Thara¹ reported that when patients became aware of the involuntary treatment, although their reaction was often negative, it did not affect their subsequent adherence to treatment. The general impression was that the patients viewed involuntary treatment positively in the long run, even though they felt aggrieved by it during the early stages. While no studies have looked at U.S. consumers' reactions to covert medication, surveys of U.S. consumers' opinions about other aspects of emergency psychiatric care may foreshadow how they would respond if asked specifically about the practice.³³ In the MacArthur Coercion study, patients placed a higher value on how clinicians communicated to and treated them over being held involuntarily.³⁴ In another study, 64 percent of mental health patients reported that, if given the choice between medication or seclusion and restraint in a psychiatric emergency, they would prefer medication.³⁵ In another study of consumer preferences, 54 percent of those who reported being in seclusion and restraint at some point said that this experience had made them unwilling to seek out subsequent psychiatric care.³⁶ The study also looked at how consumers felt about taking medication in a psychiatric emergency if they had to choose between various routes of administration. As might be expected, the respondents reported that taking oral medications was the most preferred, followed by receiving an injection that they agreed to;

the least preferred was having an injection forced on them.³⁵ Although individual values are critical to such decisions, these surveys may indicate an algorithm of options for discussion with patients, hospitals, and their communities.

Role of Psychiatric Advance Directives

If patients were allowed to tailor their psychiatric interventions in an emergency during periods of incapacity, what would be the role of psychiatric advance directives? Landmark cases including *In re Quinlan*,³⁷ *Cruzan v. Director of the Missouri Department of Health*,³⁸ and *In re Schiavo*,³⁹ have paved the road for advance directives and respecting patient's autonomy during periods of incapacity. Beginning in the 1980s, psychiatric advance directives (PADs) were introduced in the state legislatures as a means for psychiatric patients to retain choice and control over their own mental health treatment during periods of decisional incapacity.⁴⁰ Elements of PADs are intended to promote patient autonomy, allow for permission or limitations on treatment, designate a surrogate decision maker, maximize personal control over decisions, and allow for delegation of control.⁴⁰ Today, over 25 states have enacted PAD statutes and 77 percent of mental health consumers in five U.S. cities indicated that they would complete PADs if given the opportunity to do so.⁴¹ How would PADs affect the decision-making on covert medication? What would happen if a patient indicated in a PAD that during a period of incapacity in an emergency he would prefer being covertly medicated to being physically restrained and given forced medication? A recent case, *Hargrave v. Vermont*,⁴² indicates that the courts tend to side with the contract in the PAD.^{40,42} If a patient were to express a preference for covert over forced medication in his PAD, then would following this preference represent respect for the patient's autonomy and dignity?

Discussion

We are aware of no statutes in the United States that explicitly address or authorize the practice of covertly administering medications in psychiatric emergencies. Furthermore, clinicians must negotiate the tension between clinical practice in psychiatric emergencies and fundamental legal principles of informed consent, the right to refuse treatment, and substantive and procedural due process rights. None-

theless, there are ethics-based arguments for and against the use of covert medication in emergency situations. The key ethics dilemma in the emergency setting is whether avoiding unnecessary use of physical force (beneficence and nonmaleficence) outweighs avoiding deception of the individual (autonomy). Ethics considerations regarding covert medication may vary depending on the clinical situation. Clinicians should first consider whether the patient has the capacity to refuse medications and whether the situation is an emergency. We can see no ethics-based justification for covert medication in a nonemergent situation or if the patient has the capacity to make decisions. In the emergent, nonautonomous situation, before considering covert administration of medications in an emergency, clinicians should attempt reasonable measures of persuasion or show of force. Only after these attempts have been exhausted would consideration of covert medications be warranted. Any benefit of covert medication needs to be balanced with the risk of giving the medication without consent. A documented history of emotional injury, physical injury, or other adverse outcomes related to previous physical restraint may inform decision-making. When family members are available, effort should be made to include them in decision-making, and, if possible, approval from family or consent from a health care proxy should be obtained. Communications among the treating team, patients, and relatives should be transparent, avoiding secrecy in the administration of medicines, with ongoing feedback. If the team decides to covertly administer medication, it may be appropriate to inform the patient of the circumstances once he is stabilized. Psychiatric advanced directives, if available, and the patient's past and present wishes should be taken into account. Clinicians should take into account cultural factors, particularly those surrounding individual versus family autonomy. It is important for the nursing and psychiatry staff to understand clearly the patient's priorities and discuss each method of management with the patient without being prejudicial. The decision of whether to administer medication covertly should be considered by the multidisciplinary team. Families and health care proxies should be included in team discussions. Covert administration of medication must be documented. Supervisors should give staff guidance on the criteria to consider when reaching a decision on whether covert medication is justified. Procedural

guidelines and policies can assist the staff in making decisions and in avoiding overuse and abuse. As a whole, we must examine and safeguard informed consent, capacity, dignity, autonomy, and the best interests of the patient.

Conclusions

Despite the differing opinions of clinicians, patients, families, and society at large, a handful of published reports suggests that, at least in some psychiatric emergencies, medications have been covertly administered to patients. This topic raises complex questions of ethics that warrant public discussion. How does one reasonably balance competing ethics-related tensions with respect to whether covert administration of medications in psychiatric emergencies is ever appropriate? What do patients want? How will the courts ultimately rule on this question in the future? Studies should be conducted to explore the prevalence of covert medication in psychiatric emergency settings, consumer preferences on the practice, provider opinions surrounding it, and the conditions under which consensus can be built.

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