Robert C. Macauley, "Covert Medications: Act of Compassion or Conspiracy of Silence?" *The Journal of Clinical Ethics* 27, no. 4 (Winter 2016): 298-307.

# Covert Medications: Act of Compassion or Conspiracy of Silence?

*Robert C. Macauley*

**ABSTRACT**

As the population in the United States gets older, more people suffer from dementia, which often causes neuropsychiatric symptoms such as agitation and paranoia. This can lead patients to refuse medications, prompting consideration of covert administration (that is, concealing medication in food or drink). While many condemn this practice as paternalistic, deceptive, and potentially harmful, the end result of assuming the "moral high ground" can be increased suffering for patients and families. This article addresses common criticisms of covert medication and presents a detailed algorithm by which to determine whether the practice is ethically permissible in specific cases. It also explores why so little attention has been paid in the U.S. to this presumably common practice, and reviews professional statements from Europe that endorse the practice. Finally, it presents a compelling argument for the role of Ulysses clauses in advance care planning, not only for patients with psychiatric illness but also for those who may suffer from dementia, which is far more common.

## ACTUAL CASE

Mr. Smith (not his real name) is an 84-year-old man with severe dementia who is brought to the hospital from a nursing home (where he has lived for the past two years) for high fever. He previously lived at home with his wife of 61 years, until she became unable to care for him due to his increasing medical needs and her frailty. Upon admission to the hospital, he is noted to have pyelonephritis (kidney infection), and is willing to accept intravenous antibiotics. But he refuses his scheduled risperidone (an atypical antipsychotic) because he claims the unfamiliar staff "are trying to kill him." He previously accepted this medication at the nursing home, and it effectively decreased his agitation and paranoia. He now requires a one-to-one sitter, and his nursing home will not accept him back as long as this is the case. The staff wonder if it is permissible to crush his medications and conceal them in his food.

## INTRODUCTION

One of the most commonly encountered dilemmas in clinical ethics involves the conflict between autonomy and beneficence: how to respond when patients refuse what is believed to be "good" for them? When persuasion proves ineffective, only three options remain: allow patients to suffer for want of treatment, physically compel patients to take the medication (which for oral medications could be extremely burdensome or even impossible), or medicate them without their knowledge. Otherwise known as "surreptitious" or "hidden" medication, covert medication is usually accomplished by concealing medication in food or drink.[1] There are three contexts in which this practice is known to occur:

**Robert C. Macauley, MD, FAAP, FAAHPM,** is Medical Director of Clinical Ethics at the University of Vermont Medical Center and is a Professor of Pediatrics at the University of Vermont College of Medicine in Burlington, *robert.macauley@uvmhealth.org*

1. In emergency departments, as an alternative to forcible administration of medication to patients deemed at risk of harm to themselves or others[2]
2. On psychiatric units, when patients refuse psychotropic medications because of their underlying mental illness[3]
3. For neuropsychiatric reasons (such as dementia), which is the most common context[4]

The first two of these contexts specifically address mental illness, which, whether appropriately or not, is often viewed in a different light than somatic (including neurologic) illness. As a result, in many states, the requirements for treating patients who are incapacitated by psychiatric illness, over their objections, are distinct and typically more cumbersome than for patients incapacitated by somatic illness.[5] This article will focus exclusively on the third context, namely, covert medication of patients who lack DMC because of nonpsychiatric illness (specifically dementia).

Dementia is increasingly common in the U.S., affecting one out of nine patients older than 65 and the majority of elderly patients in nursing homes. In addition to impaired memory, dementia can cause neuropsychiatric symptoms such as paranoia, agitation, insomnia, delusions, and even violent outbursts.[6] Patients who have dementia that is severe enough to cause these symptoms will likely lack sufficient DMC to consent to treatment for their symptoms.

In some cases the neuropsychiatric symptoms of dementia may cause so much distrust—even to the point of paranoia—that patients actively refuse all treatment. This creates a Catch-22: the disease causes symptoms that impede treatment of the disease itself. This is especially common when something disrupts patients' established routines, such as an infection or transfer to a new environment that is full of unfamiliar faces and altered routines (as in the case presented here).

From a legal perspective, such treatment is generally not sufficiently critical or emergent to legally qualify for the "emergency exception" to treatment administered over incapacitated refusal.[7] (There is clearly suffering involved, but without significant concern for death or permanent injury.) While covert medications are not specifically addressed in U.S. law,[8] there are clear state-specific legal requirements for non-emergent involuntary treatment, as well as regulatory requirements concerning "inappropriate use" of medications that could be considered mistreatment and be subject to mandatory reporting.[9] The most uncontentious and transparent response to a patient's refusal of medication, therefore, would be to seek explicit judicial authorization by having a guardian appointed.

There are several drawbacks to this approach, the most important of which is the clinical deterioration of the patient while a petition works its way through the judicial system. Untreated neuropsychiatric manifestations of dementia may prompt a patient to refuse all medications—including those for purely somatic conditions—leading to multifactorial clinical deterioration and a potential need for isolation or physical restraint. In addition, requiring a hearing to evaluate every demented patient's refusal of treatment—which often is contextual and temporary—would quickly overwhelm most court systems. Finally, the emotional trauma of watching a loved one deteriorate for want of a medication that the family might well have been administering covertly at home[10] takes a great toll on families, many of whom question why the hospital is honoring the patient's irrational refusal.

## ETHICAL CONCERNS WITH COVERT MEDICATION

Recognizing how common this dilemma is and the legal complexities—and related clinical implications—in adjudicating it, it is not difficult to understand why healthcare facilities might consider covertly medicating a patient with dementia without court approval. Although anecdotally the practice appears to be common, to our knowledge there haven't been any epidemiologic studies in the U.S. (This telling fact will be addressed at the conclusion of this article.) British studies report covert administration in 43 percent to 71 percent of nursing home units.[11] In Norway, 95 percent of nursing home or dementia unit clinicians report that their patients have been covertly medicated at some point in the past; 11 percent and 17 percent (respectively) reported this occurred in the past week.[12] This translates to somewhere between 1.5 percent and 17 percent of nursing home patients being covertly medicated.[13] The most commonly covertly administered medications are antipsychotics,[14] which, even after a safety warning in 2005 by the U.S. Food and Drug Administration regarding a risk of death associated with their use in the treatment of dementia, are still prescribed hundreds of thousands of times per year in the U.S. for dementia-related symptoms.[15]

It is not difficult to see why some ethicists vehemently reject this approach. Their primary concern is the violation of patients' autonomy, prioritized by Western bioethics perhaps over all other

principles.[16] Secret administration of a medication a patient has refused has been described as "coercive and forced treatment at its most sinister."[17] It appears to be an example of paternalism, which Beauchamp and Childress define as "the intentional overriding of one person's preferences or actions by another person, where the person who overrides justifies this action by appeal to the goal of benefiting or of preventing or mitigating harm to the person whose preferences or actions are overridden."[18]

The practice also violates the fundamental obligation of truth telling. While not an outright lie—it would be both unnecessary as well as suspicious to inform a patient that "nobody added anything to your applesauce"—the presentation of food or drink to another person carries with it the culturally sacred understanding that it is what it appears to be, and is safe to eat or drink. And while there may be patients who are subsequently grateful for the "good cuisine" they receive during their recovery,[19] it is not difficult to imagine others who, upon learning they had been covertly medicated, become suspicious of whatever is being done to or for them.[20] In a way, the very intervention intended to reduce dementia-induced paranoia might actually justifiably increase paranoia that the meal on the tray is not what it appears to be.

Even if covert medications may be appropriate in specific situations, there remains significant concern that the practice could be inappropriately broadened for the convenience of staff, so as to pacify the occasionally agitated patient who might have responded to more time-intensive nonpharmacologic interventions.[21] The patient might have been persuaded to accept medication after being offered some control over the situation (such as by the timing of administration of the medication) or by having someone well-known administer it. All of this requires time and effort, however, which may not be readily available on an understaffed unit.[22] This is precisely what prompted legislative steps such as the Federal Nursing Home Reform Act of 1987 to prevent "unnecessary use" of such medications.[23]

Finally, the practice of covert medication could have perverse consequences for other patients who don't suffer from dementia. If the practice became known—and any ethically acceptable practice should be not only defensible but also transparent—it could potentially damage the therapeutic milieu, as every meal tray would be suspect. Even if the paranoia of an individual demented patient could be ameliorated, this broader consequence of practicing covert medication may be an example of "winning a battle but losing a war."[24]

## THE PEDIATRIC ANALOGY FALLS SHORT

Recognizing these ethical concerns, we might be tempted to defend the practice of covert medication by drawing a parallel to pediatrics, in which the practice is the standard of care, at least for young children. With the full knowledge and support of physicians, parents routinely conceal medications in food or drink to ensure that the child consumes it. This practice is based on several beliefs:

1. If patients were aware that the food or drink contained medication, they would refuse it.
2. Patients lack DMC.
3. In the absence of DMC, the appropriate decision maker (parents) must apply the appropriate ethical standard (the best interest standard), ultimately resulting in consent to treatment.

This appears to be a well-reasoned argument. It would be absurd to seek the informed consent of toddlers (which they are unable to provide) by explaining that their bottle contains medication, inviting opposition in the process. So what might be different—and more ethically controversial—about covert medications for patients with dementia?

As it turns out, these three beliefs are not always true of adults with dementia. The first is not reliable, because often patients accepted the medication in the past, and would do so under different conditions. Admittedly, some of the current conditions may not be modifiable (such as being in the hospital), but others might well be, such as a relationship to the person attempting to administer the medication. Assuming the first belief is always true runs the risk of overlooking more open and honest means to administer medication—such as enlisting familiar staff to persuade and assist—and can lead to improper application of covert medications.

The second belief is also unreliable. Whereas toddlers clearly lack any DMC, patients with dementia may have fluctuating levels of DMC, based on the time of day, state of health, and other factors. And even if patients have dementia so severe that they essentially lack DMC at all times, the fact remains that they once possessed DMC, which is not the case with small children. The significance of this is that adults with dementia have previously expressed—whether in verbal or other forms—a sense of their goals and values. The primary ethical criterion, therefore, is not best interests (as it is for young children), but rather substituted judgment.

The third belief is also more complex for adults with dementia than it is for children. Parents are the presumed decision makers for their children, for

a variety of historical, cultural, and practical reasons.[25] For adults, an appropriate decision maker is often unclear, unless the patient named a healthcare proxy. Even if the identity of the decision maker is clear, the application of substituted judgment is often more complex than determining what another individual thinks is in the patient's "best interests."[26] It is one thing to trust the obvious decision maker to do what is universally regarded as being in the best interests of a pediatric patient; it is quite another to trust someone to apply substituted judgment for an adult patients whose goals and values were once expressed, and now could be changing.[27]

## AN ETHICAL FRAMEWORK

### Prerequisites for Considering Covert Medication

Even though the pediatric analogy fails to justify covert medication, we believe the practice is both clinically beneficial and ethically defensible, as long as certain prerequisites are met and relevant factors taken into consideration.

*Verified Lack of DMC*

A patient with sufficient DMC has the right to refuse even life-sustaining treatment, and thus clearly has the right to refuse symptomatic treatment.[28] So before considering the use of covert medication, a lack of DMC must be verified and documented. Given that DMC can improve over time, the question of capacity should be revisited regularly.

Yet even if a patient lacks DMC, is this still not an example of paternalism, as critics of the practice assert? It is important to distinguish between "hard" and "soft" paternalism. The former involves overriding an autonomous decision on the part of a patient,[29] and is legally and ethically unacceptable. Soft paternalism, on the other hand, allows restricting certain conduct "when that conduct is substantially nonvoluntary or when temporary intervention is necessary to establish whether it is voluntary or not."[30] A patient with advanced dementia is not capable of making an autonomous decision, and so overriding a refusal is not a violation of autonomy.

Even so, paternalism of any sort is viewed negatively in a culture that prizes human freedom. We allow people to make "bad" decisions based on faulty reasoning, especially when the alternative is coercion and conformity. But there are limits to this, especially when a decision puts other people at risk, and also when it puts those making decisions at risk. Even the most ardent "antipaternalists" are willing to endorse certain actions that override a compromised person's decisions, such as stopping a visibly inebriated driver from getting behind the wheel of a car. Dworkin has gone so far as to assert that most rational persons would ascribe to soft paternalism as a "social insurance policy" to protect themselves from harm at times of irrationality or incapacity.[31]

Nevertheless, it is a serious issue to override any refusal of medication. This can never be done lightly. The overall benefit of intervening—or, conversely, the risk of not intervening—must provide sufficient justification. Informed consent must still be obtained (except in this case it would be from a surrogate decision maker). This is precisely the function of the next two prerequisites.

*Highly Favorable Harm/Benefit Ratio*

To justify covert medication, the harm of not administering the medication must be greater than the harm done by administering it covertly.[32] Some medications, for instance, probably don't need to be given in the first place (such as statins for a patient with limited life expectancy[33]). Forgoing other medications may not incur a risk of harm (at least in the short term, as in the case with anticoagulants for atrial fibrillation), or may not—as in the case of forgoing atypical antipsychotics—increase the risk of refusing further medication.

While respecting a demented patient's refusal of antipsychotic medication does not constitute a threat to life or limb (or else it would qualify under the emergency exception to override the refusal of an incapacitated patient), the human costs of untreated agitation and paranoia are serious. Agitation can manifest itself in physical aggression, placing the patient and others at risk. If a patient can't be discharged from the hospital, the risk of nosocomial infection increases. Beyond physical risk, for a patient to fear (even without objective justification) that "people are trying to kill me" must be incredibly frightening for the patient (as well as extremely hard for loved ones). While indiscriminate use of antipsychotics justifiably prompted the 2005 FDA warning, the fact remains that these medications (risperidone in particular) are effective in treating dementia-related agitation and psychosis.[34] On this calculus, medications for dementia-related agitation or paranoia particularly lend themselves to covert administration. These medications generally need to be administered orally over a prolonged period of time, and so the burden of either going without them or being forcibly compelled to receive them is high. As such, covert administration is often the "least restrictive means" of administering needed medications.[35]

But there is also a risk in covertly medicating a patient, specifically to a patient's relationship with a physician—as well as to family, if they are involved

in the decision—if a patient discovers what is happening, as well as to other patients if the practice affects their trust in the profession. All steps must be taken to mitigate this risk, beginning with the formulation of a rigorous ethical and clinical algorithm. This will provide reassurance to all involved—both staff and family—that more transparent steps have been explored and found impractical, and that covert administration is being done with informed consent (of a surrogate) and only insofar as is absolutely necessary to benefit the patient. This also minimizes the risk of the patient discovering what is happening by ensuring that all staff understand the covert nature of the medication.

Should patients suspect what is occurring, it is important that staff never lie. While covert medication clearly involves withholding information, once family members or staff overtly lie to patients, any hope of trust is shattered. All attempts should be made to explain the reason why the team resorted to covert medication, but given patients' impaired DMC (a requirement for covert administration) they will likely respond very negatively. This could worsen whatever paranoia is already present and make the clinical dilemma all the more complex, potentially prompting refusal of any food and drink that could contain medication. Ideally, over time, trust can be re-established, but the most important step here is prevention by ensuring that the method of medication administration remains covert.

*Discussion by the Team, Family, and Caregivers*

Harm and benefit are wide-ranging concepts that demand the involvement of family and other caregivers to determine the level of suffering involved in different courses of action. Surrogates must not only determine whether patients with DMC would have consented to medication, but also whether they would have ever wanted to be covertly medicated, if they had capacity. One could imagine patients who put such an emphasis on trust and transparency that they would never want to be medicated covertly, even if the only reason for their refusal was a lack of DMC. While beneficence would weigh in favor of covert medication, this would nevertheless represent a violation of patients' core principles and make covert medication unacceptable.

Here the "status" of a decision maker is directly relevant because it suggests the degree to which the surrogate's decisions will reflect the values of the patient. Clear designation of a healthcare proxy not only eliminates any doubt as to whom the patient wants to make decisions, but also suggests that the patient may have communicated personal goals to the proxy. If a patient has not named a healthcare proxy, there is no guarantee that the person at the top of the "surrogate hierarchy" truly understands the goals and values of the patient, especially around the idea of being medicated covertly.[36]

There is little empirical data on the opinions of family and loved ones regarding covert medication, although the anecdotal frequency of the practice at home suggests it is widely accepted. In the one published survey of people caring for a demented relative at home, the vast majority (96 percent) agreed "any helpful medications should be put in foodstuffs if necessary." These caregivers clearly expected to be involved in the decision to proceed, although in practice this occurred less than half of the time.[37]

Involving a patient's family in decisions whether or not to covertly medicate is clearly important, but their approval does not necessarily confer ethical legitimacy. For every family that is doing everything possible to keep a patient at home, there may be others who rely on the sedating effect of antipsychotics to make their own lives easier. We would be wise to heed the lesson of restraints for demented patients, once thought necessary to keep the patients safe until risks were identified and safer (albeit more time-consuming) measures were implemented.[38] The consent of an authorized decision maker, then, is a necessary condition for covert medication, but not a sufficient one. To be ethically justified, the other prerequisites need to be in place, to avoid compromising the patient's autonomy or causing harm.

In addition to family and caregivers, it is important to involve the entire interprofessional team in discussions, to benefit from their unique perspectives and skill sets. Nurses will implement covert medication and thus should be involved in the determination of whether it is necessary. Pharmacists should be consulted to ensure it is safe and effective. And while a patient's well-being is obviously the foremost consideration, the safety of staff (which affects their ability to provide adequate care) is also relevant. Patients who are withdrawn and reclusive in refusing medication present a much different challenge than patients who are aggressive—which could include hitting, biting, or exposing others to bodily fluids—thus putting staff at risk of harm.

## A STRUCTURED APPROACH

From the few published studies, it is clear that the practice of covert medication is often done in an unstructured fashion; most facilities have no formal policy.[39] Implementation is not standardized, and nurses report a lack of training in covert administration, with limited open communication about the practice with other disciplines.[40] Rates of documen-

tation vary widely, ranging from one-third to two-thirds of cases in Norwegian,[41] British,[42] and Scottish[43] nursing homes and tertiary referral facilities.

Especially for such an ethically controversial practice, transparency and standardization are paramount. Not only should the decision to medicate covertly be clearly documented, so should each administration of a covert medication. We can imagine situations in which persuasion is effective in getting a patient to accept a medication openly, thus obviating the need to administer it covertly. Such a requirement for documentation helps to prevent variation in the practices of individual staff in the practice of covert medication, which may (as noted above) become "the path of least resistance."

Figure 1 presents a structured approach to responding to a patient who is refusing medication, incorporating the prerequisites noted above. Several elements of the algorithm are noteworthy. The first is that there is a strong emphasis on a definitive determination of DMC, recognizing that patients with sufficient DMC can never be treated over their objections. Second, it recognizes that in emergency situations,[44] when time is severely limited, clinicians should proceed with treatment in the absence of clear indications (such as an advance directive, or AD) that patients—if they had capacity—would not want it. Third, there are several "off-ramps" in the algorithm that lead to a conclusion of respecting the patient's refusal, recognizing that covert medications should only be used in strictly prescribed and rather exceptional circumstances. Fourth, all reasonable attempts must be made to persuade patients to accept their medication, before even considering covert administration. Fifth, the practice requires full documentation, regular review of every individual case and annually of all cases, and external assessment (in the form of an ethics consultation).

Verification of all three of the prerequisites noted above is not sufficient to justify covert medication. Several other factors must be taken into account, each of which makes covert medication either more or less ethically acceptable. An ethics consultation provides the context to evaluate the presence of these factors, as well as to ensure that appropriate documentation and tracking are completed. (Viewed this way, the ethics consultation plays an analogous role to a guardianship hearing, without the time delay, court burden, and financial implications.)

One factor is whether patients previously accepted the medication and the level of their capacity at the time of that acceptance. If patients autonomously consented to specific medications in the past, this is strong evidence that, were it not for the neuropsychiatric symptoms they subsequently experienced, they would still agree to take the medications. Even agreeing previously at a time of incapacity is relevant to the discussion, as, absent any significant change in their health, quality of life, or goals, the shift to refusal is likely due to the change of environment or other non-ethical factors.

Another relevant distinction is between psychotropic and purely somatic medications. As noted above, psychiatric and somatic illnesses are treated differently in our society, and the laws regarding treating patients over their refusal also differ. In this case, the lines are blurry: symptoms of dementia can mimic the symptoms of mental illness, and the medications used off-label for dementia-related behaviors were developed for—and are still used for—illnesses that are clearly psychiatric in nature. (There's a reason they're called atypical *antipsychotics*.) Somatic medications are less controversial, and a dose-response relationship is often easier to establish, thus making them less ethically troublesome in terms of covert administration. And the fact remains that antipsychotics carry significant risk as well as potential benefit—as made clear in the "black box" warnings required by the FDA—so not only must all steps to use the medications openly (rather than covertly) be exhausted, all nonpharmacologic steps (such as behavioral interventions) must already be in use before resorting to the use of antipsychotics, irrespective of their manner of administration.

The reason for a patient's refusal is also relevant. While one might reasonably question whether somatic and psychiatric illnesses are as distinct as some make them out to be, the matter of whether to covertly medicate a psychiatric patient is more complex and also more ethically charged. Some mental health advocates, for example, oppose compulsory treatment of any psychiatric patient.[45] While not ascribing to that rather extreme view, we grant that overriding a patient's refusal of a medication that stems from psychiatric illness is more ethically troublesome, and thus this article focuses on dementia rather than mental illness.

The last consideration is the burden of appointing a guardian, given that some jurisdictions are more expedient than others. It is more problematic to proceed without judicial review if it can be obtained in a few days. But when the courts might not hear a petition for weeks or months, the suffering of the patient and family—as well as risk of harm to staff—may tip the balance toward proceeding with covert medication without judicial review. This is especially true for patients who might have accepted their medications willingly in the past, and might do so again in rather short order if they are administered covertly for a brief period.

**A Conspiracy of Silence?**

The claim that it is ethical (at least in some situations) to administer medications covertly is controversial, but not original. Other ethical analyses have reached the same conclusion,[46] and several formal guidelines endorse the practice, citing many of the prerequisites and relevant considerations noted here.[47] None of these, however, are from professional bodies in the U.S., nor do any provide a structured algorithm for determining whether covert medications are ethically justified in a specific case.

It is noteworthy that even though covert medication appears to be used frequently, few professional bodies or ethical commentaries directly address it. Indeed, a recent article on how to perform systematic reviews in clinical ethics—which fortuitously took this topic as a test case—identified only seven articles for inclusion.[48] Why is it that such a controversial practice is rarely discussed in the U.S.?

One possibility is that it is uncommon here, although this seems exceedingly unlikely, given how frequently it has been shown to occur in Western Europe. Or, perhaps, the ethical complexity of the practice is not recognized. This would seem odd, though, given the level of trust involved in receiving food and drink from another person, on the presumption that it is only what it appears to be (and certainly does not contain something the recipient has clearly refused). Even if clinical staff justify it in terms of giving a patient "what is needed"—and families view the alternatives as worse than the deception—what of the ethicists whose job it is to weather conflicts of autonomy and beneficence?

This leads us to wonder whether bringing this practice into the light would incur the wrath of advocacy groups who demand judicial review of any proposed treatment over objection, not to mention legal authorities who might view it as an example of "inappropriate use" of medications.[49] If so, then the quest for an ethical "high ground"—through clearly articulated and transparent policies about covert medication for specific patients—might perversely cause additional suffering by preventing any patients from receiving covert medications, if increased regulatory scrutiny pre-empted the practice.

The only alternatives to such a transparent policy, however, are to cease covertly medicating entirely (with the same resultant increase in patients' suffering) for ethical and/or legal concerns, to enact judicial reform to expedite guardianship proceedings (which appears impractical in the current fiscal and political climate), or to simply maintain the *status quo* of covert medication of unknown frequency, without training, oversight, or review. With regard to the *status quo,* it is not unreasonable to assume that covert medication happens not infrequently in the U.S., but physicians may be unwilling to write an explicit order for it, out of concern for legal liability or professional repercussions. The end result is that the practice occurs in a less reflective manner, paving the way for the very abuses that opponents of covert medication most fear. While it is ethically complex, when faced with these alternatives, covert medication represents the "least bad option,"[50] recognizing that, from a practical perspective, implementation may require legislative reform to assuage physicians' concerns regarding liability.

Ultimately, the silence about this widespread practice speaks volumes about our societal struggles with an aging population who are increasingly unable to make their own autonomous decisions, and instead make decisions that conflict with their own best interests (and often with their previously stated goals).

**Prevention, Rather than Reaction**

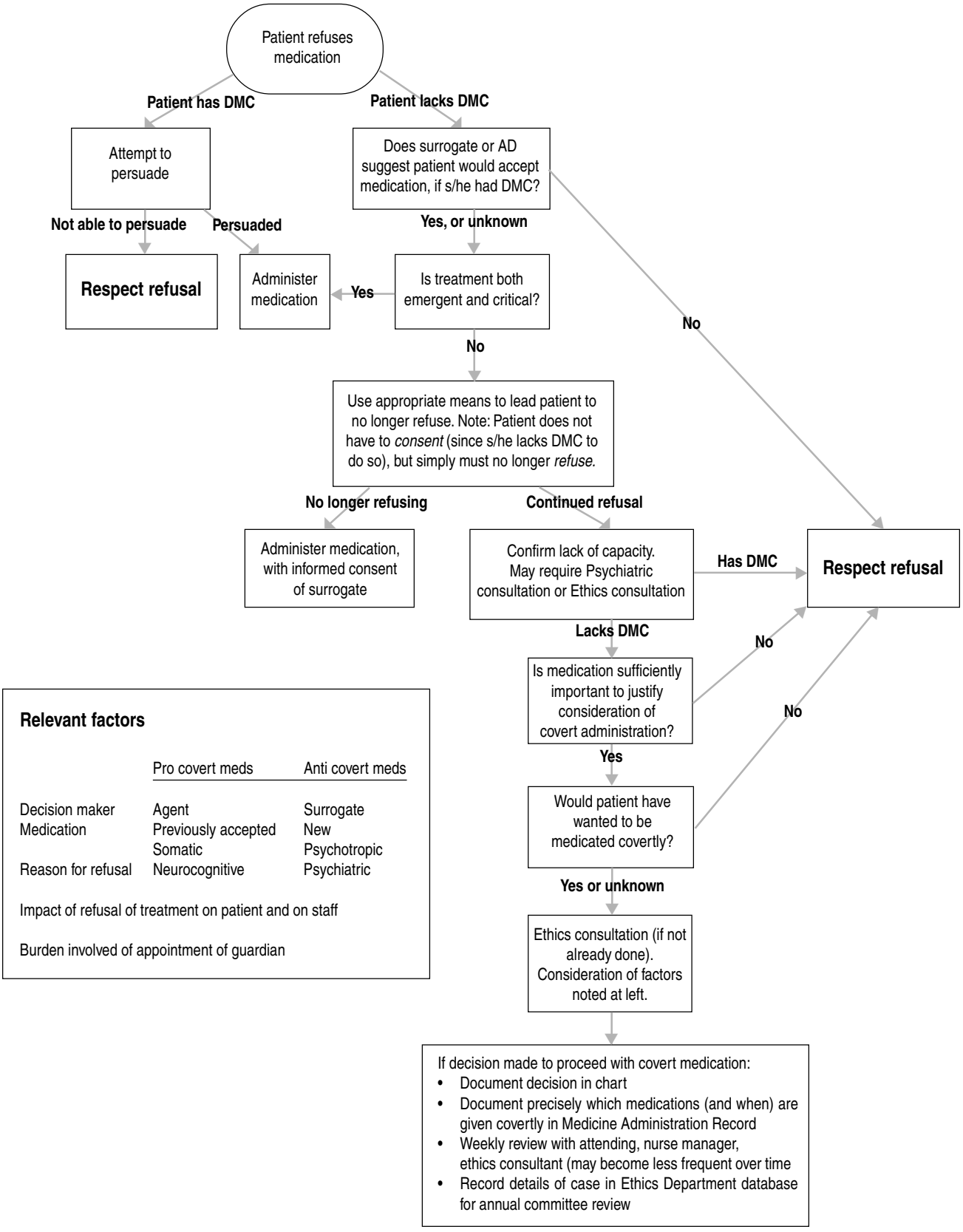
The approach presented above represents an ethically rigorous and defensible response to legally ambiguous situations in which a patient without capacity refuses medication. Yet given the documented prevalence of dementia in the elderly population, this dilemma is predictable and thus also amenable to proactive—rather than merely reactive—steps.

Psychiatric advance directives can be very important. The majority of states now recognize psychiatric ADs,[51] which go beyond standard ADs by allowing patients, at a time of sufficient capacity, to authorize subsequent treatment over their incapacitated objection. Sometimes referred to as a "Ulysses clause," these documents obviate the need for judicial review and lay to rest any concerns that patients would not want to be treated over their objections.

These documents were designed to assist patients with psychiatric illness who, for instance, experience bouts of psychosis, during which time they are more likely to refuse medication, which they ultimately regret upon finally receiving treatment and recover. From a population standpoint, however, far more people are going to suffer from dementia than from incapacitating psychiatric illness, rendering psychiatric ADs a potentially valuable preventive step in addressing refusal of medication that stems from agitation or paranoia.

This raises profound questions of personhood. For instance, is a patient with advanced dementia—which affects not only memory, but often also personality—the same person who earlier filled out a psychiatric AD? If not, then honoring that AD might constitute enslaving the subsequent person to the wishes of the former person.[52] But if a demented

**FIGURE 1.** Algorithm for evaluation of covert medications



patient is a person who has no "coherent sense of self,"[53] or even not a person at all,[54] then the patient would have no right to countermand the earlier AD.

It is beyond the scope of this article to address these questions, but, at the least, the use of covert medications can be included in ongoing conversations on the right of patients with advanced dementia to make decisions for their future selves. If the previously stated wishes of a patient with dementia are deemed compelling in a life-or-death decision, such as those related to code status or artificial nutrition and hydration,[55] then less grave decisions, such as treatment for the neuropsychiatric symptoms of dementia, can also be pro-actively addressed.

**Return to the Case**

Mr. Smith's lack of DMC is confirmed by two clinicians, and sensitive and extensive efforts to persuade him to accept the risperidone are unsuccessful. It is considered important to his recovery, although it cannot be considered "critical and emergent." Through lengthy discussions with his wife, family, and caregivers, it is felt that he would have accepted the risperidone if he had sufficient DMC, and also that he would have wanted to be covertly medicated in the event of refusal. (Regrettably, Mr. Smith had not completed a psychiatric AD.) Judicial review would take several weeks because of the non-emergent nature of the medication.

An ethics consultation is requested, which reviews all of the facts of the case and determines that this case meets the required criteria set forth in the algorithm. The nursing staff is informed that covert medication is ethically permissible, but instructed to give Mr. Smith every reasonable opportunity to accept medication willingly and to document any instances when it is administered covertly. Review of the case is scheduled at weekly intervals as long as medication is being administered covertly, and the case is recorded in a database and reviewed annually as part of the institution's quality assurance and improvement program. In a few days Mr. Smith begins to accept his medication and no longer requires covert administration. The one-on-one sitter is unnecessary. When Mr. Smith's pyelonephritis resolves, he is transferred to his nursing home.

**NOTES**

1. Covert medication specifically intends to prevent patients from knowing that food or drink contains medication. This is different than the ethically uncontroversial practice of crushing pills for patients who have swallowing difficulties, with full knowledge of what is being done.

2. M.R. Lewin et al., "An Unusual Case of Subterfuge in the Emergency Department: Covert Administration of Antipsychotic and Anxiolytic Medications to Control an Agitated Patient," *Annals of Emergency Medicine* 47, no. 1 (2006): 75-8.

3. K.S. Latha, "The Noncompliant Patient in Psychiatry: The Case For and Against Covert/Surreptitious Medication," *Mens Sana Monographs* 8, no. 1 (2010): 96-121.

4. C. Haw and J. Stubbs, "Covert Administration of Medication to Older Adults: A Review of the Literature and Published Studies," *Journal of Psychiatric and Mental Health Nursing* 17, no. 9 (2010): 761-8.

5. J.W. Berg and P.S. Appelbaum, *Informed Consent : Legal Theory and Clinical Practice,* 2nd ed. (New York: Oxford University Press, 2001) xii, 340.

6. P. Kamble et al., "Use of Antipsychotics among Elderly Nursing Home Residents with Dementia in the U.S.: An Analysis of National Survey Data," *Drugs Aging* 26, no. 6 (2009): 483-92.

7. In Vermont, state law permits treatment over incapacitated refusal only if a patient will "suffer serious and irreversible bodily injury or death if the health care cannot be provided within 24 hours." (Vermont Statute §9707.g.1.b)

8. E.K. Hung, D.E. McNiel, and R.L. Binder, "Covert Medication in Psychiatric Emergencies: Is It Ever Ethically Permissible?" *Journal of the American Academy of Psychiatry and the Law* 40, no. 2 (2012): 239-45.

9. J.M. Daly and G.J. Jogerst, "Nursing Home Statutes: Mistreatment Definitions," *Journal of Elder Abuse & Neglect* 18, no. 1 (2006): 19-39.

10. T. Srinivasan, "The Unknown User: Covert Medication: My User Experience," *Indian Journal of Psychiatry* 54, no. 3 (2012): 278-9.

11. A.J. MacDonald, A. Roberts, and L. Carpenter, "De facto Imprisonment and Covert Medication Use in General Nursing Homes for Older People in South East England," *Aging Clinical and Experimental Researc*h 16, no. 4 (2004): 326-30; D. Wright, "Medication Administration in Nursing Homes," *Nursing Standards* 16, no 42 (2002): 33-8; A. Treloar, B. Beats, and M. Philpot, "A Pill in the Sandwich: Covert Medication in Food and Drink," *Journal of the Royal Society of Medicine* 93, no. 8 (2000): 408-11.

12. O. Kirkevold and K. Engedal, "Concealment of Drugs in Food and Beverages in Nursing Homes: Cross Sectional Study," *BMJ* 330, no. 7481 (2005): 20.

13. O. Kirkevold and K. Engedal, "Is Covert Medication in Norwegian Nursing Homes Still a Problem? A Cross-Sectional Study," *Drugs & Aging* 26, no. 4 (2009): 333-44.

14. See notes 12 and 13; C. Haw and J. Stubbs, "Administration of Medicines in Food and Drink: A Study of Older Inpatients with Severe Mental Illness," *International Psychogeriatrics* 22, no. 3 (2010): 409-16.

15. J. Ventimiglia et al., "An Analysis of the Intended Use of Atypical Antipsychotics in Dementia," *Psychiatry (Edgmont)* 7, no. 11 (2010): 14-7.

16. J.S. Taylor, *Practical Autonomy and Bioethics* (New York: Routledge Taylor and Francis, 2009) xiv, 211.

17. L. Ahern and L. Van Tosh, "The Irreversible Damage Caused by Surreptitious Prescribing," *Psychiatric Services* 56, no. 4 (2005): 383.

18. T.L. Beauchamp and J.F. Childress, *Principles of Biomedical Ethics,* 6th ed. (New York: Oxford University Press, 2009), xiii, 417.

19. See note 10 above.

20. T.N. Srinivasan and R. Thara, "At Issue: Management of Medication Noncompliance in Schizophrenia by Families in India," *Schizophrenia Bulletin* 28, no. 3 (2002): 531-5.

21. L. Honkanen, "Point-Counterpoint: Is it Ethical to Give Drugs Covertly to People with Dementia? No: Covert Medication is Paternalistic," *Western Journal of Medicine* 174, no. 4 (2001): 229.

22. A. Treloar, M. Philpot, and B. Beats, "Concealing Medication in Patients' Food," *Lancet* 357, no. 9249 (2001): 62-4.

23. T. Gurvich and J.A. Cunningham, "Appropriate Use of Psychotropic Drugs in Nursing Homes," *American Family Physician* 61, no. 5 (2000): 1437-46.

24. A. Levin, "Covert Drug Administration: Win Battle, But Lose War," *Psychiatric News* 40, no. 10 (2005): 10.

25. American Academy of Pediatrics, "Informed Consent, Parental Permission, and Assent in Pediatric Practice," *Pediatrics* 95, no. 2 (1995): 314-7.

26. D.I. Shalowitz, E. Garrett-Mayer, and D. Wendler, "The Accuracy of Surrogate Decision Makers: A Systematic Review," *Archives of Internal Medicine* 166, no. 5 (2006): 493-7.

27. E. Hayasaki, "A Lesser-Known Dementia that Steals Personality," *Atlantic,* 9 January 2014.

28. G.J. Annas, "*In re Quinlan:* Legal comfort for doctors," *Hastings Center Report* 6, no. 3 (1976): 29-31.

29. J. Feinberg, "Legal paternalism," *Canadian Journal of Philosophy* 1 (1971): 105-24.

30. J. Feinberg, *Harm to Self: The Moral Limits of the Criminal Law* (New York: Oxford University Press, 1984).

31. G. Dworkin, "Paternalism," *Monist* 56 (1972): 64-84.

32. A.M. Lamnari, "Point-Counterpoint: Is it ethical to give drugs to people with dementia? Yes: It is ethical if it is in their best interests," *Western Journal of Medicine* 174, no. 4 (2001): 228.

33. J.S. Kutner et al., "Safety and benefit of discontinuing statin therapy in the setting of advanced, life-limiting illness: A randomized clinical trial," *JAMA Internal Medicine* 175, no. 5 (2015): 691-700.

34. M. Maglione et al., *Off-Label Use of Atypical Antipsychotics: An Update* (Rockville, Md.: Agency for Healthcare Research and Quality, September 2011).

35. See note 8 above.

36. In the case of a patient who did not name a healthcare proxy and for whom no surrogate is available, the only recourse would be to petition for a guardian, which would mean that the court is already involved, and the algorithm is not needed.

37. Treloar, Beats, and Philpot, "A pill in the sandwich," see note 11 above.

38. L.K. Evans and V.T. Cotter, "Avoiding restraints in patients with dementia: Understanding, prevention, and management are the keys," *American Journal of Nursing* 108, no. 3 (2008): 40-50.

39. See note 37 above.

40. L. Barnes et al., "Making sure the residents get their tablets: Medication administration in care homes for older people," *Journal of Advanced Nursing* 56, no. 2 (2006): 190-9.

41. See note 12 above; see note 13 above.

42. Haw and Stubbs, "Administration of medicines in food and drink," see note 14 above.

43. "Remember, I'm still me: Joint report on the quality of care for people with dementia living in care homes in Scotland," 2009, *http://www.mwcscot.org.uk/media/53179/CC__MWC_joint_report%20Remember%20Still%20Me.pdf*

44. The terminology in the algorithm (e.g., "emergent and critical") is drawn from Vermont law, although it can be modified to match individual state laws and regulations.

45. T. Szasz, *Psychiatric Slavery* (Syracuse, N.Y.: Syracuse University Press, 1988).

46. See note 32 above.

47. U.K. Royal College of Psychiatrists, "College statement on covert administration of medicines," *Psychiatric Bulletin* 28 (2004): 385-6; "The handling of medicines in social care," 2007, *http://www.rpharms.com/support-pdfs/handling-medicines-socialcare-Guidelines in Psychiatry*; D. Taylor et al., *The Maudsley Prescribing Guidelines in Psychiatry,* 12th ed. (Hoboken, N.J.: Wiley-Blackwell, 2015); U.K. Nursing and Midwifery Council, "Standards for Medical Management: Standard 16: Aids to Support Compliance: Disguising Medication, 5," 2007, p. 32, *https://www.nmc. org.uk/globalassets/sitedocuments/standards/nmc-standards-for-medicines-management.pdf*; NHS Foundation Trust, "Guidance for the Covert Administration of Medications," 2008, *www. humber.nhs.uk/Downloads/Services/Pharmacy/Guidelines/Covert medication guidance1 in HFT.pdf.*

48. L.B. McCullough, J.H. Coverdale, and F.A. Chervenak, "Constructing a systematic review for argument-based clinical ethics literature: The example of concealed medications," *Journal of Medicine and Philosophy* 32, no. 1 (2007): 65-76.

49. See note 9 above.

50. F. Kavaler, R.S. Alexander, and F. Kavaler, *Risk Management in Healthcare Institutions: Limiting Liability and Enhancing Care,* 3rd ed. (Burlington, Mass.: Jones & Bartlett, 2013), xxv, 530.

51. J.W. Swanson et al., "Superseding psychiatric advance directives: Ethical and legal considerations," *Journal of the American Academy of Psychiatry and the Law* 34, no. 3 (2006): 385-94.

52. R. Dresser, "Dworkin on dementia: Elegant theory, questionable policy," *Hastings Center Report* 25, no. 6 (1995): 32-8.

53. R. Dworkin, *Life's Dominion: An Argument about Abortion, Euthanasia, and Individual Freedom* (New York: Knopf, 1993), 273.

54. C.A. Defanti, "Personal identity and palliative care," in *Palliative Care in Neurology,* ed. R. Voltz (New York: Oxford University Press, 2004), 327-34.

55. D. Callahan, "Terminating life-sustaining treatment of the demented," *Hastings Center Report* 25, no. 6 (1995): 25-31.