EDITORIAL

Covert medication: Do means justify the ends?

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This issue of the *Indian Journal of Psychiatry* brings to readers a vigorous debate on the covert or surreptitious medication of difficult patients with major mental illness. Several authors offer their thoughts on the subject; one of these is a parent who has practiced covert medication in a personal context, and another is a client who has received covert medication in the past. Arguments for and against the subject are proposed, some emotional and others cold in logic. Although to medicate a patient without his knowledge and against his likely wishes appears intuitively improper, we wish to play the devil's advocate and discuss why there may be merits in covert medication as an approach by a troubled family to re-establish homeostasis in the household. In our discussion, rather than reproducing the arguments already well expressed in this issue of the journal[1-7], and elsewhere[8-14], we introduce or emphasize lines of thought that have received little or no attention in the debate. The views that we express are our own; readers may therefore note that our article does not represent an official position of this journal or of the society of which this journal is an organ.

There are six relatively independent matters that we address on the subject of covert medication of a difficult, uncooperative, and sometimes violent patient with major mental illness. Each of these is considered in turn.

A MATTER OF RISK: THE UNKNOWN PATIENT

Covert medication of a patient who has not been formally assessed by a psychiatrist is unwise, unsafe, and illegal. There is no assurance that the history provided is genuine or, if genuine, accurate. Most practitioners would agree with these assertions. Nevertheless, most practitioners also know of unusual cases in which patients were covertly medicated by their families as the only practical way in which the patients could be brought into treatment for the first consultation. The emphasis here is on the word "practical" for, although legal avenues exist to treat the uncooperative, mentally ill patient, these avenues are almost always too impractical or too traumatic for most families. The clinician, therefore, faces a difficult situation: Does the potential benefit of covert medication by the family outweigh the risk that the diagnosis and treatment is wrong?

A MATTER OF PRACTICE: DO PATIENTS REALLY MAKE AN INFORMED CHOICE?

India has only a few thousand psychiatrists who cater to the mental health needs of over 1.2 billion citizens. As a result, psychiatrists are overburdened with case loads and have little time to provide patients with education about diagnosis and the effects of prescribed medications. Thus, patients do not really make an informed choice about their treatment, and autonomy is indirectly violated almost as a rule. The only difference between this situation and covert medication is that in the latter, the patient is ignorant not only about his diagnosis and treatment but also about the fact that he is receiving treatment. The administration of depot antipsychotics is another example of how autonomy is indirectly violated because it amounts to daily dosing with no capacity to withdraw consent in between.

These are admittedly strange arguments to support covert medication, but the obvious point is that ethicists should consider the ecological background in which covert medication occurs before they rule on the subject. That is, if "Take this and don't argue because I think it's best for you" is widely practiced and even accepted as right because it is done with good intention (paternalism), is covert medication with good intention really all that different or bad? To a family in distress, these distinctions

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How to cite this article: Sathyanarayana Rao TS, Kallilvayalil RA, Andrade C. Covert medication: Do means justify the ends?. Indian J Psychiatry 2012;54:203-5.

Access this article online

Website: www.indianjpsychiatry.org

DOI: 10.4103/0019-5545.102331

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and their implications for autonomy are meaningless. The applicability of autonomy as an argument is examined in later sections of this editorial and a guest editorial in this issue.[15]

A MATTER OF WHO COMES FIRST: THE INDIVIDUAL OR THE FAMILY?

In Western societies, families drift apart or fragment easily and emphasis is laid on the rights of the individual. In Eastern societies, in contrast, the family is a strong unit and the rights of the individual tend to be subsumed by the family. Therefore, ethical principles that are well established in the Western world need not necessarily be appropriate in Indian life because what is best for an individual may not be best for the family with which he lives. Consider that the illness of the patient does not occur in a vacuum and that it does not affect the patient alone; it occurs inside the family unit and affects the living environment of the patient. As a result, the living environment, the family, is an important stakeholder in the patient's recovery.

This can best be understood in the context of how patients with major mental illness present in India: they are almost always brought by their families. Furthermore, hospitals in this country hardly ever admit a voluntary patient unless he is accompanied by a family member. An inevitable realization is that the unit of treatment is not just the patient; it is the family. The rights of the family in which the patient lives may therefore override the rights of the patient in the matter of mental health, behavior, and risks. The family has a right to want the affected member, whom they love, to recover. The family has the right to want a restoration of their emotional, social, financial, and legal security when an individual member suffers a serious mental illness. The family may even consider that it has a duty to resort to covert medication, if needs be, to prevent the patient's mind and the family's security from being driven off a cliff. This makes sense when one considers that in India (unlike in the West), the family is legally responsible for patient. In this context, clinicians should understand that they themselves violate no ethical guidelines if the family chooses to bring delusions, hallucinations, and abnormal behavior under control through the covert administration of antipsychotic medication in situations of crisis.

A MATTER OF AUTONOMY: HOW MUCH DOES ONE REALLY HAVE?

Autonomy is a loose concept that is situationally invoked or applied. Autonomy is far from the norm. Every law that exists, whether written or not, infringes on autonomy. Many regulations violate autonomy even in matters of health. For example, in several parts of the world, including states in India, it is compulsory for a motorcyclist to wear a helmet. Why compel somebody to protect against an accident that has not occurred and that might never occur, and yet allow another, who has a major mental illness, to make his own choices when a wrong decision can irreversibly harm not only his own health and security but also that of the family in which he lives?

A MATTER OF RIGHT VS. WRONG: IT DEPENDS ON PERSPECTIVE

All arguments for or against covert medication are eventually based on the premise that something is right or wrong; as an example, it is wrong to violate the autonomy of a patient who is competent to understand his options regarding treatment and able to make his own choices in this regard. However, right and wrong are not absolute; past history and current events show us that different countries or cultures, and different generations within the same country or culture, exhibit widely differing opinions on right and wrong. Views on expressions of sexuality, ranging from masturbation to homosexuality, best illustrate this point. Therefore, easy as it is to preach from ivory towers, it is debatable whether persons not involved in the care of a disturbed, mentally ill person should impose their beliefs (right vs. wrong) about covert medication on the family unit affected by major mental illness. Additionally, professionals and lawmakers should be doubly careful about transplanting Western notions of what is right and wrong to Indian environments in which these notions were not tested. Finally, right and wrong are polarized concepts, and ethicists should realize that the real world is not as simple: black and white may exist as distinct entities, but there is a great deal of gray in between which cannot and should not be ignored. Most patients for whom covert medication is considered fall in these gray areas: one cannot assert with certainty that a course of action is right or wrong.

"A MATTER OF REGULATION: DON'T FIX WHAT AIN'T BROKE"

Should there be regulation against covert medication? No. Therapists do not provide interpretations and foster insight into maladaptive defenses unless they are able to foster better coping; maladaptive though those defenses may be, in their own way, they protect the ego from harm. In similar vein, it would be unwise to enforce change in the current scenario of covert practice of covert medication until a better solution is available. True, a patient will not be happy if he discovers that he has been medicated against his will; but will he be more pleased if he is subjected to greater cruelty by being forcibly admitted, detained, and treated against his will under the provisions of the Mental Health Act? As an amusing thought, would the Mental Health Act permit the compulsory admission of a psychotic patient but allow him the right to refuse treatment in the hospital?

Should there be regulation permitting covert medication?

No, because it would result in legal sanction of a possible abuse of powers (by psychiatrists and families) in the absence of supervision.

So, what should be done? There is no evidence that when families covertly help patients recover through the surreptitious administration of medication, the result is more often harm than good. As the saying goes, "Fools rush in where angels fear to tread." Along these lines, we suggest that if something is not broken, let us not hurry to fix it through regulation. Clinical experience, anecdotal reports, and stray studies suggest that covert medication can help patients and families in distress. Imperfect though the situation is, covert medication appears to provide help in circumstances of need. Let us not meddle.

CONCLUDING NOTES

Covert medication of the unwilling patient is common.[8] It is undesirable because it violates the patient's autonomy and can create an atmosphere of distrust between patient and family. Nevertheless, there are difficult situations in which the distressed family has no other realistic options. In such situations and during the period of crisis, covert medication may be justifiable. However, covert medication as an everyday form of treatment is not a desirable practice.

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