The practice of illicitly administering medication to schizophrenia patients who refuse or resist treatment has had virtually no public discussion. Although the scope of this practice is unknown, the article in this issue by Srinivasan and Thara and reports of concealed medicines in analogous patients with dementia suggest that it is of growing importance. A recent survey by Treloar and colleagues (2000) found that the strategy of hiding medication in foodstuffs was used in 71 percent of 34 inpatient and residential settings that cared for patients with dementia in England. Srinivasan and Thara (this issue) now report that it is a common practice for patients with schizophrenia at their clinic in India.

The Study

Srinivasan and Thara (this issue) surveyed 254 family members of outpatients with schizophrenia in Chennai, India, regarding the use of concealed antipsychotic drugs in response to medication refusal. Of the 148 family members of noncompliant patients who responded, half reported giving medicines to their ill relative without the relative’s knowledge. In “almost all” cases this was done on the advice of a psychiatrist. Usually the concealed medication was given for only a few days, but in 14 percent of cases the concealed treatment lasted for more than a year. In a quarter of cases, patients later found out that they had been given medicines surreptitiously. Many of those who found out had negative reactions, specifically anger and resentment toward the family members who gave the medicines. However, most of the patients who were given concealed medicines subsequently took them openly and voluntarily.

The authors note that this practice may be culturally appropriate for India, where psychiatric services are sparse, most persons with schizophrenia live with family members, and family members are the primary caregivers. Because families gave the hidden medicines on the recommendation of a psychiatrist and most medicines were administered for short periods of time to avert crises, the authors conclude that having family members conceal medicines in this way may be a viable solution to the common and difficult problem of medication refusal in other sociocultural settings as well.

The major shortcoming of the Srinivasan and Thara study is its selection bias. Even if we assume that the 254 families in the study represent all patients in their clinic or are a representative sample, they still do not represent all families who may have tried concealing medicines. If patients did not later take medicines “openly and voluntarily,” they would probably not have been engaged in outpatient treatment at the settings where subjects for this study were recruited. Thus, families who tried concealed medicines without success may have been systematically excluded from the survey. This selection problem leaves unknown the full dimensions of the practice in India, as well as the proportion of patients who are angered by the deception and subsequently are lost from treatment.

Ethical and Legal Implications of Concealed Medicines

Among the many interwoven problems raised by the administration of concealed medicines are legal issues, ethical issues, cultural factors, and clinical judgments. We analyze these issues from the perspective of contemporary Western law and ethics, in the belief that core ethical principles have universal applicability. However, we recognize that the weight given to a particular principle may vary across cultures, and hence analyses undertaken from different cultural perspectives might lead to different conclusions.

The key ethical principles relating to the use of concealed medication are autonomy, justice, beneficence, and respect for persons. Autonomous patients are presumed to
be able to make decisions for themselves. Although autonomy is a fundamental principle underlying health care, it must be balanced by the need for public safety and ideals of beneficence and duty to provide care. The great deference afforded individual autonomy and independence in the United States and many other Western societies may not generalize to cultures where familial interdependence is stronger and collective goals of the family are dominant. Justice must also be considered in the concealed medicine debate because persons with mental disorders are not treated justly if they are deprived of fairness, including due process. Beneficence in the pursuit of an individual’s “best medical interests” is the likely rationale for using concealed medicines for a person who does not take them voluntarily. Respect for persons, however, requires that the dignity of a person be respected even when his or her autonomy is subordinated to other interests.

In Western medicine, these ethical principles find their way into the treatment setting through the doctrine of informed consent. The principles of informed consent for medical treatment, although well established in the United States, are not as clearly established in India (Jacob and Rajan 1991). The basic requirements for informed consent are that adequate information is provided for the individual to make an informed decision, that the person is competent to make the decision, and that the decision is made voluntarily. Competence requires the ability to understand the relevant information, to appreciate the nature of the situation and its consequences, to rationally manipulate the available information in order to make a decision, and to express a choice (Berg et al. 2001). Clearly, people given concealed medicines have not been engaged in informed consent. Among the few exceptions to informed consent are true emergencies, therapeutic privilege wherein the physician determines that full disclosure would be harmful to the patient, waivers by the patient, and lack of competence (Berg et al. 2001). Individuals may also appoint others as decision makers when they are unable to make decisions. The relevance of these exceptions in the case of concealed medicines is discussed below.

The refusal of medicines may result from competent or incompetent decision making. If the decision maker does not have the ability to understand relevant issues, appreciate their implications, or reason about the consequences of decisions, that person lacks the capacity to make the decision at hand and eventually may be adjudicated incompetent. When an adult is determined to be incompetent, a substitute decision must be made. In general medical settings where extraordinary forms of treatment (e.g., sterilization) are not involved, decisions are typically made by family members. Many U.S. jurisdictions, however, now require formal adjudications of incompetence before psychiatric treatment can be administered to an incompetent patient. Once the 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 on an outpatient basis in only rare circumstances. Even under involuntary outpatient commitment, forced medication is usually prohibited without guardianship proceedings and consent of the guardian.

When a patient is competent to make a decision about medicines and simply does not want the recommended treatment, the situation is complex and troublesome, particularly when there is no short-term danger of self-harm, no danger of harm to others, and no impairment in self-care. Best interest or prevention of future harm arguments may still apply; analogously, these are the justification for “outpatient commitment” programs that require outpatient patients to attend medical appointments based on past or predicted future behaviors.

Advance directives or health care powers of attorney in which persons, when competent, give instructions for desired care during potential future periods of incompetence may offer a solution in some instances (Swanson et al. 2000). It is possible that an advance directive could permit the administration of an injectable medicine, although this might still involve the use of force. Treloar and colleagues (2000) have argued that advance directives may not work for concealed medicines because they would require that people consent in advance to be deceived. However, this is a restricted view of how advance directives might be used. An advance directive could specify a desire for medicines without any indication of how they would be given. Concealed medicines would then be an option that avoids force and is consistent with the advance directive’s instructions.

To what extent might the exceptions to informed consent apply to the situation described by Srinivasan and Thara? The emergency and incompetence exceptions are most relevant here. The need for intervention in an emergency situation is widely accepted. For example, forcibly injecting tranquilizing medicines is a common approach in emergency wards and on psychiatry inpatient units. Informed consent for treatment is not required in clear emergencies that result from a medical condition, because the patient’s consent is implied. In potentially dangerous situations that occur at home, it may be reasonable to allow usual caregivers to intervene with concealed medicines if there is a clear indication of an emergency and a...
formal treatment setting is inaccessible. This may apply
even in situations where formal settings are available but
inadequate or otherwise problematic, if it is a family’s
preference to manage the situation rather than resort to
formal providers. Concealed medicines also have the pos-
sible advantage of avoiding physical harm if a patient is
expected to violently resist taking medicine. But such use
of emergency concealed medications should clearly be
short term.

We suspect that many of the family members inter-
viewed by Srinivasan and Thara, if asked to think in these
terms, would justify their actions by reference to their rela-
tives’ incompetence to make treatment decisions. In a
jurisdiction in which physicians are empowered to deter-
mine patients’ capacity, and family members are empow-
ered to consent to treatment, decisions about involuntary
treatment may well be made without resort to the courts. If
family members can consent to involuntary administration
of medication, why can they not legitimately use con-
cealed medication?

Here is where an aspect of the principle of respect for
persons becomes relevant. Use of deception arguably implicates considerations beyond those involved in overtly
subordinating a patient’s refusal of medication to other
interests. The deception of concealed medicines involves a
manipulation of persons—albeit for benevolent ends—that
denies their dignity by depriving them of the right to know
what is being done to their minds and bodies. Hence,
respect for patients as persons becomes another factor that
weighs against use of concealed medication, even for
incompetent patients.

Clinical Implications

Concealing the administration of medication to patients
raises a set of clinical issues that go beyond ethical con-
cerns. Without informing their family members, patients
may consume other medications or psychoactive sub-
stances that interfere with the therapeutic effects of the
concealed medication or are otherwise problematic. It may
be difficult to persuade patients to go to the clinic for peri-
odic monitoring and necessary blood tests. Few antipsy-
chotic medications are administered to patients without
engendering some side effects, often resulting in abnormal
bodily sensations. Thus, patients may experience restless-
ness (akathisia), reduction in spontaneous movements
(akinesia), sedation, and the like. However, patients may
not report these side effects, which might be manageable
with an alteration in dosage or type of medication pre-
scribed. And patients who are unaware that these effects
are attributable to medication may ascribe them to malev-
olent forces impinging on their bodies, reinforcing or
expanding their delusional beliefs. Moreover, the secretive
nature of this form of treatment makes it hard to prevent
abuse—for example, the use of medicines punitively or for
the convenience of others.

The use of concealed medicines may be discovered by
the deceived patient. Short-term anger is a likely result, but
greater risks are alienation from family and more entrenched
resistance to medicines. In addition, therapeutic alliances
with physicians overseeing medication administration may
be damaged, and longer term therapeutic efforts may be set
back significantly. A severe potential problem is the risk of
retribution by the deceived patient. Slipping something into
the food of someone who is suspicious and paranoid may be
frankly dangerous for the person who attempts this decep-
tion, because a paranoid person’s hostility and aggression are
commonly directed at people perceived to be controlling or
trying to harm them.

Finally, if there develops a general belief that the psy-
chiatric profession routinely conspires in the deception of
patients, other concerns will arise. Persons in need of
treatment may be reluctant to seek care from professionals
they see as untrustworthy. Advice from psychiatrists may
be ignored or viewed with suspicion if tainted by the wide-
spread use of deceptive practices.

Service System Perspectives

An understanding of the service system context and legal
mechanisms for obtaining care is critical to evaluating the
value and acceptability of using concealed medicines. In
most of India, mental health services are extremely limited
(Ganju 2000). This may make family members more vul-
nerable to potential harms and burdens than in settings
with better access to services and may provide a rationale
for decisive action at home. Culturally appropriate infor-
mation is critical to evaluating the value and acceptability
of using concealed medicines, perhaps involving concealing medicines, may thus be acceptable.

However, where appropriate legal mechanisms and
service providers are available for helping manage med-
ication refusal, using families to administer medicines
covertly has little justification. Doctors who make this rec-
ommendation may simply be shifting additional burdens
to families. Because inpatient commitment to ensure a
patient’s safety is legally sanctioned and widely available
in Western countries, this option should be pursued when
necessary. In systems that provide outreach through
assertive community treatment teams or similar programs,
these services should be accessed.

Perspectives of Families

The issue of family administration of medicines is of criti-
cal importance, not only in countries where formal ser-
services for people with schizophrenia are limited, but also in more advantaged countries like the United States. A significant proportion of persons with schizophrenia live with family members in both developing and developed countries, although nuclear families are becoming less common in industrialized countries. In the United States, families consistently feel more “burden” when they live with patients than when they live separately, and when patients have higher levels of symptoms (Stroup et al. 2001). For family members who live with someone with schizophrenia, the risk of violence is real (Estroff et al. 1998; Swanson et al. 1999). Understandably, the desire to reduce burden and the risk of violence may motivate families to provide concealed medicines to their relatives with schizophrenia.

In the survey of Srinivasan and Thara (this issue), the majority of families (54%) who gave concealed medicines later felt they had taken the right action. Forty-one percent of respondents held this position less strongly: they acknowledged that the technique was not ideal but thought it was practical under the circumstances. Only 4 percent retrospectively regretted their action. This is consistent with the views of informal caregivers of dementia patients surveyed in England by Treloar and colleagues (2000). In this study, 98 percent of survey respondents agreed that “medicines for severe mental distress should be put in foodstuffs if necessary,” and 86 percent disagreed with the (unfortunately compound) statement that “all patients have the right to choose and should never be given medicine in foodstuffs.” Furthermore, 40 percent of informal caregivers who had difficulty getting their relatives to take medicines had put the drugs in food or drink (Treloar et al. 2000).

Families who use concealed medicines are often struggling to manage a situation that is largely out of their control. The other choices include living in fear of danger to themselves, others, or the patient; bearing the acute or chronic situation with forbearance, hopeful that the episode will pass or that their powers of persuasion will prevail; and using the available professional resources, including laws for inpatient or outpatient civil commitment that would mandate some sort of action, ranging from mandatory appointments to mandatory treatment with medication. When persuasive methods do not work, family members in the United States may attempt coercion by giving an ultimatum like “take your medicines or move out,” knowing there is some sort of service system in place but also knowing that there will be a risk of homelessness and danger. In other cultural settings this kind of threat is highly unlikely, and often there is no service system available.

The recommendation from a psychiatrist to conceal medicines may add an unwelcome burden and may put family members at risk of retribution from the patient. On the other hand, some families may feel empowered by this cooperation with the psychiatrist and the possibility of providing something of perceived benefit to their family member.

Perspectives of Patients

Srinivasan and Thara (this issue) report that patients who learned that they had received hidden medicines were angry and resentful. Nevertheless, all of the people in their study then went on to take the medicines openly. As discussed above, the available evidence provides no indication of how most recipients of hidden medicines might react upon learning they were tricked into taking medicine. Acceptance of medicines in the end, as seen in this sample of clinic patients, is one possibility. But anger and resentment may not pass quickly. The result may be that a person leaves home, running the risk of the homelessness and separation from family that the hidden medicines were intended to help avoid. Anger may result in hostility and aggressiveness. It is not surprising that suspicious patients may become hostile when deception is detected. The risk is real and significant; we know of a case of matricide in New Zealand when a mother hid antipsychotic medication in her son’s food.

Role of Psychiatrists

When the issue of concealed medicines is raised—as it may be by concerned family members in any culture—psychiatrists and other mental health professionals must be aware of this practice and able to offer direction. We believe that professional caregivers have three options: (1) actively recommending concealed medicines while providing supervision and monitoring to ensure that the patient fares well and that the practice is not misused; (2) passively allowing the practice to take place without providing any explicit advice or monitoring other than simply providing the medicines with a description of possible side effects and remaining available for questions and emergencies; and (3) attempting to prevent the use of concealed medicines and offering alternatives. These three approaches are discussed below.

First, a physician’s advocacy of concealed medicines and active supervision of families who use this approach may appeal to desperate families and help them avoid some of the anguish of watching their family member go untreated or taking full responsibility for the deception. This approach allows a physician to help monitor drug effects and side effects, and to provide some protection against abuse by family members. Given that both family members and
physicians may have conflicted interests, additional monitoring seems necessary. In the United States, liability for such a practice should be considered. Unless an applicable exception to informed consent (i.e., emergency situation or incompetence) is documented, failure to obtain informed consent could result in grounds for civil actions. Even if an exception to informed consent is in place, it is wise to keep careful documentation and obtain a second opinion. In cases of incompetence, a valid substitute decision maker should be in place and engaged in the process.

Second, a passive role by a physician may be both the most common and the least desirable course of action. In one scenario, the physician does not provide any suggestions or even acknowledge that medication is being administered, perhaps fearing that acknowledgment or documentation of advice in this matter may lead to criticism or legal action. The doctor takes no responsibility, plays a very modest role in monitoring the medicines, and leaves the family to bear responsibility. Another scenario might have the physician recommending against the practice but not making efforts to stop it, and also providing medical and emotional support for the family.

Third, stopping or preventing the use of concealed medicines may alienate families who do not like the available alternatives and may feel this will result in additional suffering by the patient and themselves. The most direct way to stop the process would be to stop prescribing the medication. Another would be to make the patient aware of the deception. Doctors who choose to stop or prevent the hiding of medicines must help develop an alternative treatment plan that includes crisis contingencies.

Discussion

Concealing medicines is yet another approach to helping treatment-refusing patients by caregivers who oppose the idea of letting persons with mental illness “rot with their rights on” (Gutheil, 1980). Unlike legally sanctioned methods, including civil commitment to inpatient and outpatient settings, the practice of concealing medicines for persons with schizophrenia has not been widely debated, probably because concealing medicines is inconsistent with informed consent, now a key foundation of contemporary Western biomedicine.

Should a psychiatrist routinely direct family members to conceal medicines? We think not. Concealing medicines violates principles of autonomy and respect for persons and the requirements of informed consent, and the practice may result in poorly supervised use of powerful medications. In almost all circumstances involving persons with schizophrenia, medicine concealing should be avoided.

What should a psychiatrist do if he or she learns that a family is providing or intends to provide concealed medicines to control behaviors, maintain safety, prevent hospitalization, or simply help a family member? Family members are often reluctant to resort to civil commitment procedures. Concealing medicine in food seems less traumatic than taking steps to have a child, spouse, or parent taken to the hospital by force, given the anger and resentment that can result. With concealed medicines, there is the hope of improvement and a chance that the deception will not be discovered and anger will be avoided.

Given the strong pressures on families, perhaps it is naive to think that psychiatrists can have a significant influence over what families do with medicines. Nevertheless, we recommend intervening to try to find a better solution than concealing medicines. This is often possible if there is a reasonably accessible service system. Outpatient commitment should be pursued if it is available. Inpatient commitment may ultimately be required. Legally sanctioned compulsory medicines can be implemented if necessary.

Compulsory treatment is not appealing, but it has advantages over concealing medicines. Regulations and the involvement of professional caregivers can help prevent the misuse of compulsory treatment and ensure its safety. Legal jeopardy is minimized, although ethical dilemmas persist. The long-term consequences of deception are avoided.

Noncoercive methods of helping persons with schizophrenia are, of course, desirable. Psychiatric advance directives may offer a partial solution. Empathy, support, and forbearance by family members and formal caregivers are essential. Continued psychoeducation, in a nonhostile, noncritical manner, may slowly have an effect. Monitoring for dangerousness is needed so that emergency services can be accessed as necessary.

Innovative approaches to helping people with schizophrenia who refuse medicines are direly needed. Psychiatric advance directives may offer a solution that is consistent with current ethical principles, but empirical understanding of the effectiveness of this approach is still extremely limited. New approaches must balance the principles of medical ethics, legal requirements, the rights of patients and their family members, and public safety.

References


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