Ethical dilemmas

Covert medication

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About this series

This is the sixth and final piece in a short series looking at real-life ethical dilemmas concerning people with diabetes and their primary care health professionals.

The authors' objective is to raise awareness in this important and complex part of person-centred care, where the boundaries are grey and the answers are varied and depend on who you talk to. This can cause misunderstanding for all concerned; therefore, some important ethical principles that underlie clinical decision-making are outlined.

The case scenarios have been anonymised so that they bear no resemblance to the original person with diabetes.

The authors recognise that there are wide-ranging opinions and possible ways forward in all of the ethical cases in this series. They are not trying to highlight expert clinical management, but instead wish to demonstrate the contrasting ethical viewpoints that contribute to decision-making processes.

Authors

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Scenario

by **Juliette Mathie**, Practice Nurse

Mr M is a 79-year-old man with type 2 diabetes and dementia. His diabetes was well controlled in the past as his wife used to ensure he took his metformin and sitagliptin regularly. She was his main carer but sadly developed metastatic breast cancer and died 12 months ago.

Since her death he self-neglected, culminating in several hospital admissions with confusion and hyperglycaemia secondary to poor concordance. After the third admission in 6 months he has been cared for in a local nursing home but still regularly refuses to take his prescribed medication and regularly tries to "go home".

He has a niece but no other close relatives. She is asking about him being given his medication disguised in his food so that he remains well and hopefully avoids another admission.

Ethical principles covered

The European Court of Human Rights regards medication being given against someone's will or without the person knowing as a "deprivation of liberty", and many people regard any covert medication as both paternalistic and unlawful.

This issue is about protecting the rights of an individual. If Mr G were capable of giving informed consent or dissent, then the debate would have to stop there – and await a predictable crisis if the "virtuous ethics" healthcare practitioner were not able to seek a negotiated compromise.

With thoughtful consideration and the following of due process, covert medication has a limited but important and appropriate role – if no medication were given at all this can be regarded as neglect of care. Clear documentation of the process and decision-making is essential.

If there were no recognised advocate for an individual, an Independent Mental Capacity Advocate (IMCA) should be contacted.

Ethical discussion of the scenario

by **Chris Elfes**, GP

One seemingly reasonable question here actually encompasses a wide range of complex ethical decision-making. In the past, infirm nursing home residents, especially those with behavioural issues, were given covert or even overt unwanted medication – often referred to as a "chemical cosh". It finally took published evidence of the increased cerebrovascular and fall-related risks, in combination with far-improved recognition of the rights of cognitively impaired people, to change attitudes.

This "best interests" request can now create anxiety in the minds of many healthcare professionals. In these circumstances, the capacity and understanding of Mr M needs to be clarified, his current physical and mental well-being established and the views of his niece and carers sought. If he lacks capacity to make these decisions, we need to ask: what were his probable pre-morbid wishes and does his next of kin have a lasting power of attorney for medical matters? And do we know if the good concordance when his wife was alive was because of their long-term relationship, his capacity at the time, or the possibility that she was covertly ensuring he got his medication even then?

The deontological argument is clearer, thanks to the Mental Capacity Act Deprivation of Liberty Safeguards (DOLS). If he is effectively being kept in a nursing home against his will, as he lacks capacity, the nursing home manager MUST request a DOLS assessment.

The request and any decision is "controversial" and, therefore, as with many ethical issues, enough information needs to be gathered and several stakeholders need to be involved in the decision-making process.

A "best interests" decision, given the current facts and consequentialism arguments, will probably support the use of covert medication, but this is not a decision for a lone healthcare professional to make.

Many competing ethical arguments could have been used in this – and any other – scenario but we have been restrictive in those used in each of the short scenarios in this series.