Surreptitious Prescribing in Psychiatric Practice

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Throughout medicine, and particularly in psychiatry, treatment nonadherence by patients remains one of our greatest challenges. Estimated rates of nonadherence among all psychiatric patient groups range between 20 and 50 percent, and this figure rises as high as 70 to 80 percent among patients with schizophrenia (1). Treatment nonadherence is associated with poor outcomes for patients with schizophrenia, and efforts aimed at improving adherence have provided mixed results (2). In one study, compliance therapy, based on motivational interviewing, improved medication adherence, attitudes to treatment, and insight at six months (3). However, a similar study did not replicate these findings (4). A recent review concluded that current clinical interventions to improve adherence, such as psychoeducation and predischarge contracts, need frequent repetition and are unlikely on their own to improve medication adherence among patients with schizophrenia (5).

To improve the care of patients with severe mental illness, clinicians and family members sometimes resort to concealing medications in food or drink—a practice referred to as surreptitious prescribing. In this paper we describe advantages and disadvantages of surreptitious prescribing in the context of community psychiatric service. We also examine its legal and ethical aspects and present guidelines for clinicians who are considering the surreptitious prescribing of medications.

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Surreptitious prescribing

Surreptitious prescribing is the practice of supplying a prescription to a family member or health care professional of a patient and knowing that the medication will likely be concealed in food or drink and administered to the unknowing patient. Most clinicians can recall scenarios in which medication was administered in such fashion. Medical treatment is often given without consent in emergency or life-threatening situations (6). In pediatric circles there is a precedent for drugs being administered surreptitiously, a practice accepted by both clinicians and parents (7).

Although this practice is not well described in the psychiatric literature (8), it is, nevertheless, more common than one might imagine. In one study of 50 elderly patients, 79 percent received their medication surreptitiously (8). For patients with dementia this figure was 94 percent (8). In a survey of 21 psychiatrists, 38 percent admitted to having participated in surreptitious prescribing (6). However, this figure is likely to underestimate true practice, because many respondents felt uncomfortable on direct questioning about admitting to deceiving their patients. Fear of professional censure results in minimal discussion or recording in patients' case notes, which serves to compound the atmosphere of secrecy and suspicion (9,10).

Advantages

Surreptitious prescribing has a number of potential advantages in treating patients suffering from severe mental illness. Serious clinical risks and substantial costs are associated with delay in treating patients with acute psychiatric illness (11). The toxic effects of untreated psychosis are also well documented (12,13). Delaying psychiatric treatment among such patients is associated with increased morbidity and poorer outcomes in terms of prolonged individual suffering, increased risk of self-destructive behavior, deterioration of the therapeutic alliance, and increased physical assaults by the patient. Additionally, delay in initiating treatment of patients with acute psychiatric illness can lead to the demoralization of health care professionals and redirection of limited clinical resources to nontherapeutic activities. Surreptitious prescribing raises the possibility of intervening at an earlier stage before relapse and the need for certification and admission to the hospital.

Surreptitious prescribing can also prevent the need to repeatedly restrain and forcibly administer injections to patients. Family and caregivers often find this form of prescribing more satisfying, because it may also reduce the need for certification and the use of seclusion and restraint. In the case of patients with dementia who forget to take medication because of cognitive decline, restraint can be viewed as a cruel substitute for surreptitious administration (14).

A significant evidence base exists for family involvement in the management of psychotic illness (15,16), and surreptitious prescribing could be viewed as willingness of the family to be more involved in a patient's care.

Disadvantages

Prescribing surreptitiously runs the risk of denying the patient the opportunity of gaining insight. In some cases, insight improves only after recurrent relapses with the realization by the patient of the relationship between nonadherence and relapse. Surreptitious prescribing may serve to reinforce the patient's view that illness is not present and that he or she does not require treatment. The practice may also discourage patients from availing themselves of psychiatric treatment, because some may perceive surreptitious prescribing as granting too paternalistic a role to psychiatrists. Furthermore, some people may view surreptitious prescribing as a cheap means of managing inadequate staffing levels and thus encouraging untidy practice. Surreptitious prescribing also runs the risk of overlooking research and not improving our understanding of why patients are noncompliant in the first place. Patient, doctor, medication, and illness factors are associated with poor compliance, and ultimately our goal should be to better understand the reasons behind noncompliance and address these reasons before resorting to surreptitious prescribing.

Legal and ethical issues

Many of the disadvantages of surreptitious prescribing are related to legal and ethical issues. The major risk for clinicians who prescribe medication surreptitiously is that they are in effect taking the law into their own hands. One must question whether this form of prescribing in psychiatric care is necessary or legally defensible given the legal methods for involuntary committing and treating patients—involuntary hospital admission, outpatient commitment, and appointment of a guardian—that are outlined in mental health legislation. Furthermore, antipsychotic medications are associated with well documented side-effects, including extrapyramidal movements and sudden death in some circumstances.

Malpractice suits against doctors and health facilities and product liability suits against manufacturers of antipsychotic drugs have taken place in the United States and Canada among patients who developed tardive dyskinesia as a result of taking antipsychotic drugs. Certain jurisdictions believe that a doctor who proceeds without consent will be liable for trespass, assault, or battery. This view is in keeping with the 2000 guidelines of the Royal College of Psychiatrists and stands regardless of whether the doctor believed that what he or she did was good for the patient (17). In such cases the doctor could be prosecuted as an accomplice to battery.

The use of surreptitious prescribing for a patient lacking mental competence is a key issue. Mental competence reflects the ability of a patient to evidence a choice, understand the given information, appreciate or believe its content, and reason about the given information (18). In cases in which a patient has competence to consent to or to refuse treatment the clinician should proceed with the wishes of the patient. Lack of mental competence qualifies a patient in most jurisdictions for detention and enforced treatment under mental health legislation. One alternative might be to prescribe medication surreptitiously; however, this places the determination of competence solely with the clinician.

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A further limitation of surreptitious prescribing is the legal implication of a relative acting as the proxy decision maker for a patient without mental competence. This legality varies across countries. For example, in the United Kingdom relatives do not have such powers (except in Scotland), and decisions need to be made in the patient's best interests. However, we are unaware of any jurisdictions where a proxy can make a decision for a competent patient, except young children.

From an ethical point of view, surreptitious prescribing could be viewed as a form of misuse of power and a breach of the trust in the doctor-patient relationship from the patient's perspective, as the patient is unaware of treatment received. The involvement of relatives and caregivers in the process also raises the issue of breach in confidentiality. These factors may result in irreversible damage to the therapeutic relationship in some cases. Although some may view surreptitious prescribing as a deprivation of the rights of the patient, it is also worth remembering that, paradoxically, withholding medication necessary to effectively treat mental illnesses could also be viewed as a deprivation of the patient's rights.

Guidelines

The most critical aspect of surreptitious prescribing relates to the legal implications involved. For this reason the clinician must assess the competence of the patient to give informed consent on an ongoing basis, because competence may vary over the course of a psychotic illness in conjunction with insight. Even competent patients with dementia may lack competence during an episode of delirium and regain it with resolution of the acute confusional state. If the patient regains mental competence as a result of medication administered surreptitiously, the clinician has a duty to involve the patient in future treatment decisions. In such cases, advance directives may help with the decision process, because the patient could conceivably give informed consent to the clinician at a time when he or she is deemed mentally competent, and the clinician could proceed with surreptitious prescribing when

the patient is considered to lack competence. While weighing the advantages and disadvantages of surreptitious prescribing, the clinician must also consider the clinical implications of withholding treatment from such patients. Obtaining a second opinion from a colleague or the local ethics committee could reduce the legal and ethical dilemmas.

The involvement of family members and other caregivers is essential, and all potential benefits and risks of surreptitious prescribing should be explained in advance to the family and caregivers. It is also advisable to obtain the family's consent in writing. Furthermore, the family's motivation must be well-intentioned and not based on a desire to tranquilize and quiet an ill relative. Before proceeding the clinician should have a documented history of recurrent relapses secondary to medication nonadherence. All factors associated with nonadherence should also be examined, and every intervention as a means to improving adherence should be exhausted. These efforts include providing psychoeducation, avoiding polypharmacy, minimizing or treating side effects when possible, improving social and family support, and ensuring good quality of service provision and delivery of care. Furthermore, surreptitious prescribing should not be considered as a means of managing staff shortages.

The paramount principle is ensuring the well-being of a patient who lacks the competence to give informed consent. It is likely that no single rule can be applied to all cases, and any decision should respect the patient's viewpoint and also that of the family or caregivers who are integral in maintaining the patient's good health. The final decision is likely to be multidisciplinary, involving all health care professionals involved in the patient's care. ♦

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