What’s in the Pudding?

Dementia and psychosis are common diagnoses for individuals in residential treatment and inpatient facilities. Symptoms include emotional instability, disorientation, confusion, fear, and aggression. In the process of providing care, such individuals may be labeled as “non-compliant” because they are often resistant to taking medication. Patients may or may not have legitimate reasons for this resistance. Some dislike the side effects, others never consented in the first place, while others refuse as a way of simply maintaining bodily autonomy. Some patients however may consent and agree with their medical treatment during lucid moments, but at other times be resistant to medication due to symptoms of their psychosis or dementia. Staff frequently implement strategies to force compliance with treatment goals, including taking medications. (While over-medication is sometimes and issue, in general it is best that patients take their prescribed medications.) One such strategy is covert medication administrations—that is, concealing medication, mostly in food or drink, so that the patient does not know about the drug.¹

Dementia patients exhibit diminished decision-making capacity and autonomy (although the degree of impairment is both on a spectrum and can fluctuate). Nonetheless, this reduced capacity is often taken to justify paternalistic deceit about medication administration. It is generally considered better for patients if they do not become agitated and medication administration can be quite stressful. Nurses are also often understaffed and over-burdened. The process of administering medications to a non-compliant, disoriented patient is stressful, time consuming, and in extreme cases potentially dangerous. For these reasons some view covert administration of medication as a choice which provides benefits to the patient, staff, and other dependent patients.

Deception, such as covert medication administration, can negatively affect both the patient and the nurse. Patients have less power and knowledge than medical staff and must place their trust in the staff. When patients detect deception, trust in caregivers is broken. Once trust is broken, it can be challenging to repair: the patient may not be able to accept even the most basic care from that person again due to damaging the relationship with deception. The discovery of deception can go beyond the situation and affect the way that the individual perceives healthcare professionals in the future. Even when no discovery is made by the patient, there is a worry that deception in justifiable cases will lead to an erosion of staff commitment to veracity in general.²

Research indicates that specific demographics of patients are more susceptible to covert medication administration in residential and inpatient treatment facilities. According to experts on covert medication Julia Simpson “There may be unintentional biases at work.”³

On Simpson’s analysis of covert medication administration, race, age, and other medically irrelevant elements of diagnosis and treatment plans affect medical decision making about when deception is warranted. For example, evidence shows that black patients are more than twice as

---

likely to be diagnosed with schizophrenia compared to white patients. And black men with schizophrenia are comparatively over medicated and receive less therapeutic interventions than white patients.⁴

© Association for Practical and Professional Ethics 2020
Case from the 2020 Regional Intercollegiate Ethics Bowl.

---