An Ethical Dilemma

A nurse is suspended

A day hospital sister was suspended and given a final formal warning for obeying the request of her consultant to give a patient tranquillising medication in disguise. Though a disciplinary inquiry exonerated the consultant, the action on the nurse has not been rescinded. This case questions the authority of the multidisciplinary team and the role of nursing managers. We asked two geriatricians and forensic scientists to comment on the case.

The case

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WP was a 91 year old widower recently admitted to an old people's home. Although normally pleasant, he showed unpredictable aggression. Some days he was unusually bombastic but returned to normal the next day after a long sleep. Doctors thought that this might indicate temporal lobe epilepsy, but as he correctly pointed out he had never had a fit, and he refused electroencephalography or anticonvulsant drugs. He was cognitively intact and physically strong, although arthritis meant that he needed a Zimmer frame to walk.

He was near to being expelled from the home when he was persuaded to attend a day hospital for elderly people. He spent the first two weeks making model houses to collect money for charity. On 14 August he arrived at the day hospital in buoyant mood. During the day his mood varied from determined volubility and grandiosity to irritability and impatience. At 3 pm he was invited into the ward round, when he firmly declined the offer of admission or a tranquilliser. The team felt he was hypomanic and unsafe to return to his home without treatment, and his general practitioner and social services were asked to complete a section 2 for compulsory admission.

The nurses in the day hospital were asked to try to persuade him to accept admission or drugs while the team completed the hospital rounds. At 5 pm the consultant returned. The sister and an occupational therapist had remained behind over an hour after their shift had ended to look after WP, who was angry that he had missed the returning ambulance and demanding to be discharged. The consultant made a further attempt to persuade him to stay, or at least take drugs but retreated when WP threatened him with his frame. He considered that he had three options: Firstly, he could allow the patient home untreated, putting at risk not only the residents of the home but his residential place. Secondly, he could call on several nurses to be on hand while he attempted to inject haloperidol. He had little doubt that WP would have put up a determined resistance leading to risk of physical injury to WP and the staff, loss of rapport, and an insult to WP's self respect. Thirdly, he could give him 10 mg of liquid haloperidol disguised in a cup of tea.

The sister was now the only member of staff the patient trusted, and when he asked for a cup of tea the consultant decided to add haloperidol to the tea which the nurse gave to him. This had the calming influence necessary and he came to the ward.

The next day he was back to his usual self. He agreed to electroencephalography, which confirmed a temporal lobe focus, and accepted anticonvulsant drugs, which pre-

vented further attacks. He was told about his surreptitious medication and he agreed that it had been the right course of action. In gratitude he gave the consultant one of his model houses. His nephew also strongly supported the action. Despite this the hospital unit general manager subsequently instructed the consultant to stop releasing information of this type to relatives or patients.

Disciplinary action

On 23 August the hospital sister, who had a blameless record, was instructed to leave the hospital after collecting her cards from personnel and to make no attempt to contact her colleagues or the hospital until further notice. She was suspended on the orders of the chief

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nurse, who maintained (wrongly as it transpired) that giving WP haloperidol in his tea was specifically prohibited in "the guidelines." The chief nurse did not contact the consultant.

A single immigrant, the sister returned to her flat alone until her hearing was called on 3 October. The tribunal upheld the view of the chief nurse and sent a letter to the sister stating that her "misconduct would normally result in summary dismissal" but that she was being issued with a final formal warning because she had realised that her actions were unacceptable, and it was difficult for her to disobey her consultant. She was told that she must submit to further training by the chief nurse and his deputy (who had reported her action but had done nothing to prevent it). Already so depressed that she could hardly talk, she remained on sick leave for a further five weeks.

The consultant was invited to meet with the hospital's unit general manager and the senior community physician to discuss the incident. The facts had never been in dispute, and the consultant was formally disciplined to await the result of a regional inquiry. The consultant was strongly advised to avoid publicity until the results of the inquiry were available.

Views from outside

While waiting for the inquiry the consultant received confirmation from the consent to treatment committee of the Mental Health Act Commission that his action had been within the act, and the chairman of the committee admitted that he would have done the same. The assistant registrar on ethics of the United Kingdom Central Council for Nursing, Midwifery, and Health Visiting (having considered the details sent by the consultant, a copy of which was sent to management) wrote that the council's guidelines were not rules but standards. The principle of justification was satisfied in the circumstances. The two psychogeriatricians appointed by the region not only supported the action

taken by the consultant but criticised the action of the authority in suspending and disciplining the nurse.

The consultant tried to obtain the support of his colleagues but was told by the medical director that it was subjudice and could not be discussed in any meeting of colleagues at which he was present. As the director was chairman of the medical staff committee and the informal committee of consultants, this inhibited discussion with colleagues. The director likened the action to having intercourse with a patient, "it may not harm the patient but it is equally wrong."

Conclusion

Two years later the nurse still has the judgment on her record. In October 1995 the consultant finally heard the outcome of his disciplinary action. The board accepted the recommendations of the independent assessors that the consultant was not guilty of professional misconduct. However, they sought a formal undertaking that this practice would not occur in future and would not take action to modify the "sentence" on the nurse. They were content with a situation where a nurse had nearly been dismissed for obeying the instruction of her consultant who was behaving professionally. The chief nurse remains in post and no one in authority has expressed any sympathy to the nurse concerned.

This account also casts doubt on the authority of the multidisciplinary team, which both before and after gave its approval to the action taken, when its decisions can so easily be overturned by people outside the clinical arena.

Drugging a patient without his or her knowledge is a last resort, and many may consider that a forcible injection was preferable. Regardless of the ethics of this action it seems surprising that a senior nursing officer can single out for discipline a conscientious and excellent nurse who was doing what she thought was her duty, while the consultant responsible was allowed to practise unhindered.

Commentary: Treatment was not unethical

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Some features in this report are puzzling and disconcerting, but there are also grounds for reassurance for both patients and clinicians. The problem described is one which, in general terms, will be familiar to many doctors. Accepting that there are occasions when all measures short of drug administration may fail, is it permissible to administer such drugs against the patient's will, and if so should they be given by force or is deceit sometimes an allowable and preferable alternative?

For mentally competent patients it is clear that in common law no treatment can be given without valid consent. However under part IV of the Mental Health Act 1983 there are provisions for certain treatments to be given without consent, as well as measures to safeguard psychiatric patients' interests in relation to treatment procedures. This applies to a patient "liable to be detained" under the act and is therefore relevant in this instance, where plans were being made to complete a section 2 for compulsory admission. "Chemical restraint," as it is called, is defined in the code of practice as "medication for management purposes either with or without an additional therapeutic intent." Any treatment given must not be irreversible or hazardous, must be immediately necessary, and should represent the minimum interference necessary to prevent the patient from behaving violently or being a danger to himself or others. It seems clear that these criteria were fulfilled in this particular case.

How may such drugs be administered? The phrase in the act "if medication has to be administered by force"

makes it implicit that this is an option. It is difficult, however, to find written guidance on the question of deception. It seems sensible to us that it should be in a way which is least likely to be harmful to the patient. The phrase mentioned above that treatment should represent the minimum interference necessary would seem compatible with this view.

We suspect that similar incidents to that described here are relatively common and are certainly aware of instances of drugs being administered without the patient's knowledge when the patient is disturbed and not mentally competent. In paediatric practice there is also a precedent for drugs being administered surreptitiously. This seems accepted both by clinicians and parents. It is reassuring that the approach taken by the consultant and the sister in this case was supported by the consent to treatment committee of the Mental Health Act Commission and also by the psychogeriatricians appointed by the region.

We are puzzled why the case caused such a problem. It seems commendable that the staff discussed the episode with both patient and next of kin subsequently, and the response was obviously supportive. Openness about such action seems laudable, but the account implies that such frankness was viewed with concern in some quarters. Nevertheless, we feel it is reassuring for the public that clinical decisions which may be contentious are subject to scrutiny and are reviewed in various forums. However, once the reviewing bodies have pronounced, management would be well advised to heed their advice.

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