NATIONAL CURRICULUM IN REPRODUCTIVE PSYCHIATRY

Primary Psychotic Disorders

Perinatal Ethics

Self-Study Case Vignette

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Learning Objectives

1) Understand general ethical principles that impact clinical decision-making in perinatal psychiatry.
2) Identify necessary steps in evaluating a patient for involuntary psychotropic medication.
3) Approach evaluations of capacity for pursuing pregnancy termination.

Case Presentation: Part 1

Danielle is a 35-year-old G2P1001 currently pregnant at 17+3 WGA, with psychiatric history of schizoaffective disorder, who was referred to the family planning clinic for elective pregnancy termination.

According to the OB/Gyn resident, Danielle was very excitable on interview. She spoke with a loud voice, and kept leaving her exam room to roam around the clinic. Danielle reported variously that her baby was a demon, that the father of her baby had died, and that the father of her baby was alive and affiliated with a gang who would come after the baby if she didn't terminate her pregnancy. Danielle's mother reported that she's been taking "pills" intermittently, but they haven't seemed to help. She also reported that Danielle had been seen at two other clinics for termination, but was unable to obtain the procedure because she became very agitated both times. She was eventually escorted to the emergency room for psychiatric evaluation.

Interview in the emergency department is difficult due to Danielle's disorganization. She denies any symptoms of acute psychosis (including auditory or visual hallucinations, thought broadcasting, or paranoia). She states several times that she wants an abortion, and asks for the date of her procedure, but otherwise changes topics quickly and often answers questions with non-sequiturs. Twice she attempts to climb into the examiner's lap and gives hugs during the interview. Danielle's mother expresses concern that her condition seems to be worsening. She is not sure whether Danielle has been taking medication regularly. She also reports that during similar episodes in the past, Danielle has spent hours wandering around their high crime neighborhood, sometimes getting into altercations with strangers.

When asked about inpatient psychiatric admission, Danielle remains adamant that her only problem is needing an abortion. She does not believe she needs any sort of psychotropic medications, and does not wish to sign in voluntarily.

Discussion Question

1) What is the appropriate disposition for this patient? What factors would you consider in making this decision?

Case specific discussion:

- In this case, Danielle demonstrates numerous symptoms of acute psychosis. It is possible that her symptoms may be worsening due to medication nonadherence – many patients discontinue medications upon learning that they are pregnant. It is also possible that physiologic changes of pregnancy may be affecting metabolism or serum levels of her medications, leading to acute decompensation.
- Danielle is presenting with florid psychosis, and there is considerable reason to be concerned that she is unable to meet her basic needs in her current state. Her history of wandering around unsafe streets for hours and getting into altercations during prior episodes is also highly concerning, as she is placing herself at significant risk of harm. It is conceivable that her emphasis on obtaining a termination – and inability to complete the procedure at multiple clinics – could escalate to inadvertent self-harm, if she tries to self-induce abortion.
- Although Danielle denies suicidal or homicidal ideation, she's at risk of significant (inadvertent) harm to self, and is likely to decompensate further without acute intervention. Inpatient admission would be optimal; criteria for involuntary admission vary by state, but she is likely to qualify in most states.

General perinatal ethical principles:

- Anticipate that female patients of child-bearing age who are diagnosed with psychotic disorders may become pregnant at some point in their treatment. Have discussions about desires and plans regarding treatment should they become pregnant, as well as about contraception. Provide education in anticipation to avoid hasty decision making when a patient does become pregnant. Treatment throughout pregnancy may prevent the need for higher doses of medication and/or polypharmacy often needed to stabilize an acute episode.
- When treating a pregnant patient with a psychotic disorder, consider both the risks of medication treatment and the risks of untreated mental illness. It is important not to overlook the risks from failing to treat because of an omission bias. Discussion should focus on both the risks of untreated illness and the risks/benefits of medication.
  - Mental illness itself has an increased risk of negative pregnancy outcomes. Risks of untreated psychotic illness in the pregnant woman may include: increased psychotic symptoms, suicide, violence, poor self-care and poor prenatal care, increased substance misuse.
  - Untreated maternal psychotic illness also has potential negative effects on the fetus/infant, including: low birthweight and prematurity, higher neonatal morbidity, impairment in bonding and behavioral difficulties.
- Consider the principle of relational ethics to guide decision making. This ethical principle emphasizes that a pregnant individual's well-being in intertwined with the well-being of her fetus. A woman who harms her fetus in response to command auditory hallucinations will likely experience a severe decline in her own well-being.

Similarly, when a woman with a severe mood disorder discontinues effective medication during pregnancy, she is likely to experience a recurrence of illness with associated risks to the fetus. What is in the maternal patient's best interest is usually in the best interest of the infant/fetus. Provide education about this to the mother and her support system.

- Seek to enhance a women's decision-making, by providing guidance and helping her understand the issues and probabilities of negative outcomes rather than relying on her perceptions from the media or her friends/family's experiences.

Case Presentation: Part 2

Danielle is involuntarily admitted to inpatient psychiatry under certificate and petition. She remains on the unit for several days, but refuses to accept any medications. Throughout her stay, she is hyperverbal, speaks in a loud voice, and is fairly intrusive with other patients. Most days, she follows her rounding team all over the unit, and has to be redirected frequently to give other patients privacy. Her thought process remains very disorganized, though she is quite consistent in stating that she needs to terminate her pregnancy as soon as possible. She receives frequent emergency injections of diphenhydramine and haloperidol for agitation; it is noted that she shows some improvement the day after an emergency PRN – she's better able to follow a conversation and more appropriate in respecting personal space. At these times, she continues to ask about when her termination is scheduled.

Discussion Question

2) Would you petition for Danielle to receive court-ordered medications? What additional information would you gather to inform your decision?

Consider involuntary or forced medications when an acutely psychotic pregnant or postpartum woman is refusing treatment despite a clear need. The provider should evaluate Danielle's capacity to make decisions about her psychiatric treatment, including appreciating the diagnosis and its consequences; understanding relevant information about treatment; rationally manipulating this information; and communicating a choice. Involuntary medication is worth considering in this patient, given the severity and persistence of her psychosis, and history of placing herself in extremely dangerous situations when similarly ill. Moreover, Danielle seems to derive meaningful benefit from emergency administration of antipsychotics, indicating that more regular medication could significantly improve her condition.

Danielle's psychiatric team should work with her OB/GYN providers to discuss risks and benefits of involuntary treatment. Risks and benefits of antipsychotic and mood-stabilizing medications in pregnancy are discussed at length in this and other modules. Briefly, the potential risks of leaving Danielle's psychosis untreated are quite concerning. By comparison, consider that the risk of both antipsychotic medications such as risperidone, and lithium, are relatively low at this point in pregnancy. Depending on state laws, involuntary ECT may also be a consideration.

Although Danielle is requesting termination, her team must keep in mind the possibility that the pregnancy may be carried to term, and should consider potential fetal effects of treatment.

See the table below for a recommended approach to involuntary treatment evaluations in pregnancy:

Table 3 Suggestions for Completion of Evaluation for Involuntary Treatment in Pregnancy

Start with standard forensic approach for forced treatment
Know the law in your jurisdiction (*Rennie* or *Rogers* model)[37,38]
Diagnosis
Rationale for need for treatment
Reason capacity is lacking
Determining less restrictive alternatives
Knowledge of literature on fetal and pregnancy complications
Clearly identify harms of no treatment in report; others may focus only on medication harms or may be ignorant of the risks of not treating
Communication with other medical staff (e.g. obstetrics and pediatrics), since risk is outside usual area of forensic expertise
Clearly understand trimesters (for example, the point at which the fetus becomes viable, the medications that may pose a risk during different trimesters/weeks, and the length of time bed-rest needed)

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Case Presentation: Part 3

The team submits a petition for involuntary psychotropic medication to the circuit court. There is a delay of four weeks between submission of court paperwork and the hearing. Danielle's mother appears to testify, and is able to give excellent collateral that when she's adherent to her home regimen of risperidone and lithium, Danielle is typically able to help around the home and provide care for her 12 year old son. The petition is granted, and at 21+4 WGA, Danielle is started on risperidone, which is up-titrated over several days to 2mg in the morning and 4mg at bedtime. As treatment progresses, Danielle shows fair improvement, though she continues to be somewhat intrusive and disorganized, and does not demonstrate capacity to care for herself in an outpatient setting. She is re-started on lithium, which is gradually increased from her usual dose to target a therapeutic serum level.

She continues to request termination of her pregnancy, though she no longer appears to believe that the baby is a demon. The current law in your state prohibits termination after a fetus

becomes viable (generally accepted as 23 – 24 WGA). The family planning service at your hospital is extremely busy, and would like to reserve OR time as soon as possible.

Discussion Question

3) How would you approach Danielle's request for termination now that her psychiatric condition appears to have improved significantly? How might the impending legal deadline of 23-24 WGA affect your decision-making?

Although Danielle is by no means at her psychiatric baseline, there is significant time pressure to pursue termination while it is still legally permitted. Her psychiatrist should work with the family planning team to carefully assess capacity for this decision.

Decision making in Pregnancy Termination:

- Ethical principles include balancing autonomy by respecting capacitated reproductive preferences and beneficence-based obligations to protect the woman from harm.
- An informed consent termination discussion involves the effect of pregnancy termination on the patient, effect of continued pregnancy on the patient, and the patient's values and beliefs.
- Pregnancy termination discussions occur within the context of local laws around pregnancy termination and in cases of an individual under guardianship, the scope and limitations of the guardianship authorities in her jurisdiction.
- Considerations around protections or rights for the fetus change over the course of the pregnancy based on viability. The mother's health is the central outcome during decision making and is rarely subordinated to the health of the fetus.
- A pre-viable fetus may be conferred the status of fetal patient when a pregnant woman confers such status on it, thus this may come into consideration for a guardian or capacitated decision-maker.
- In situations where a woman lacks capacity then a substituted or surrogate decision maker is identified.
- Substituted judgment should make a decision based on the patients long standing values or preferences if these can be identified either from the past or from the present if the patient can appreciate the reality of her circumstances. If values are unknown, then the surrogate decision maker should use the best interests standard as a guide.

No legal guardian:

- Assess patient's decisional capacity around pregnancy termination in the four areas of ability to communicate a choice, ability to understand relevant information, ability to appreciate the nature of the situation, and ability to manipulate information rationally
  - If she retains decisional capacity, then after an informed consent discussion her decision should be respected.
  - If she does NOT have capacity and that is potentially reversible, then attempts should be made to enhance decision making capacity through treatment or

alternate presentation of the informed consent material (e.g. repetition, visual materials).

- If she does NOT have capacity and that does not change, then a substitute decision maker should be identified.

Determining a legal and ethical plan for decision making with guardianship:

- First assess legal scope of guardianship around pregnancy termination decision making.
- Assess patient's capacity to make decisions regarding pregnancy.
- If indicated, amend guardianship to give authority around pregnancy termination.
- Determine patient's preferences to inform substituted judgment decision. Unless the patient is unable to participate due to significantly diminished capacity (e.g. denial of pregnancy, active self-harm) then include the woman in the process to promote autonomy and determine substituted judgment with greater fidelity.

Case Presentation: Part 4

By 22+5 WGA, Danielle has not required PRN medications for several days, and appears sufficiently organized to participate in informed discussion of termination. When asked about her reasoning, she states "I'm too old to have another baby," and "I can't afford a baby." She goes on to state, "I'm going to school to be a secretary right now…who would take care of him?" She reveals that she has had a termination once before, and is able to both describe the procedure in reasonable detail and comprehend basic risks. Danielle's mother is in agreement with pursuing termination.

Given that that Danielle has been consistent in her request for termination, is able to provide reasonable rationale, has the agreement of the family member who would otherwise serve as a surrogate decisionmaker, and her history of prior termination suggests that this procedure would not violate Danielle's previously held beliefs or values, she is scheduled for the next available OR slot.

Termination is completed successfully and without complication. Danielle opts to have a Mirena IUD placed at the same time. She remains on the inpatient psychiatry unit for a few more days, as lithium is tapered back down, and discharged on her pre-pregnancy doses of both lithium and risperidone.

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