Evaluation of the Decision-Making Capacity of Two Cases Planning to Undergo Uterine Evacuation

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SUMMARY

Psychiatric disorders in the perinatal period can lead to a deterioration in one's judgment and decision-making ability. These disorders may cause sensitive and complex legal and ethical issues relating to psychiatric, obstetric, and neonatal care. Clinicians should ethically respect the autonomy of the individual, but at the same time, they must assess the individual's decision-making process with the use of forensic psychiatric and consultation-liaison psychiatric practice. While the literature related to mental disorders in pregnancy has been increasing, there is limited information regarding the medico-legal and ethical aspects of this topic. Herein, we present two cases who are pregnant and have psychiatric disorders, and we aim to discuss their evaluation process of uterine evacuation.

Keywords: Forensic psychiatry, pregnancy termination, uterine evacuation, decision-making capacity

INTRODUCTION

Decision-making capacity refers to the evaluation of one's cognitive skills in a certain context and in relation to a specific condition. In mental disorders, decision-making capacity should be evaluated for one's current mental state (Maçkalı 2014).

Psychiatric disorders in the perinatal period may lead to poor judgment and bad decision-making. These disorders may also cause complicated and sensitive matters of psychiatric, obstetric, and neonatal care that may require legal and ethical attention (Dudzinski 2006). Mental disorders during the perinatal period can cause mortality and morbidity for both the mother and the baby (Oates 2003, Zalpuri et al. 2015). Based on the DSM-IV-TR, approximately one out of four pregnant women were diagnosed with a psychiatric disorder, while approximately one out of twelve women had a psychiatric disorder at the onset of pregnancy (Vesga-Lopez et al. 2008). It is known that women with mental disorders are less informed about methods of pregnancy prevention, and unplanned pregnancies are more frequently observed among this population (Miller ve Finnerty 1998, Zalpuri et al. 2015).

Clinicians evaluating a woman in the perinatal period must, on one hand, ethically respect the autonomy of the individual, but should also examine her decision-making process based on consultation-liaison psychiatry practices. While the literature related to mental disorders in pregnancy has been increasing, there is limited information regarding the medico-legal and ethical aspects of these situations. Herein, we discuss

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the evaluation process of uterine evacuation of two cases who are pregnant and have psychiatric disorders.

Case 1

Case 1 is a 28-year-old married woman with no children. She was first diagnosed with bipolar disorder 10 years ago after she applied to an education and research hospital with a clinical presentation of mania and was treated there as an inpatient. Since then, she has had six hospitalizations, two of which were in our clinic. In 2013, she was forcefully hospitalized in our hospital with a diagnosis of a bipolar disorder-manic episode. During her hospitalization, her pregnancy was recognized, and the situation was evaluated by a board including faculty members from the department of gynecology and obstetrics. The board decided that the patient lacked sufficient evaluation and judgment skills due to her present psychiatric condition (manic episode), and was therefore unable to make a reasonable decision. Her family and husband were informed, and with the consent of her husband, the uterus evacuation was performed in the eighth week of the pregnancy.

In a more recent visit, the patient applied to the gynecology and obstetrics clinic with complaints of amenorrhea. The patient was evaluated to be 19-weeks-pregnant, and there were no malformations in the fetus, even though the patient was on regular valproic acid and lithium treatment. The pregnancy was unplanned, and prevention methods had not been used. Because she had terminated her previous pregnancy, the patient was referred to our clinic for a mental examination and psychiatric evaluation for the option of termination.

In the mental status examination, there were no disruptions in consciousness, orientation, affect, and reality-testing other than some findings on the slowness of associations, poor thought content, and borderline intellectual functioning (IQ: 71). There was no history of alcohol or substance abuse, suicidal thoughts or previous attempts, or current physical illnesses.

The comprehensive psychiatric evaluation made after meeting with the patient, her husband, and her family suggested that the detected shortcomings should not impair the patient's decision making capacity, and a board report was documented based on this evaluation. The reasons behind this conclusion were as follows: a) the individual's bipolar disorder was under control through treatment, and she was not currently effected by the disorder; b) Although the individual had borderline intellectual functioning, it was not at a level that would deteriorate her juridical capacity; and c) Any other problems or conditions that would medically or legally weaken the individual's capacity to decide whether to continue the pregnancy to birth were not detected.

Both the individual and her husband decided to continue the pregnancy. She was recognized to be capable of caring for the baby as its mother. In addition, she would be able to receive support from her own mother. The patient was included in the routine pregnancy-monitoring program.

Case 2

Case 2 is a 35-year-old married woman with two children. The patient, who had no previous history of mental disorders, began having complaints of anxiety, distress, crying spells, and guilt about not being a good mother 3 months ago after her 21-month-old daughter died in an accident. Two weeks after the accident, she found out about her pregnancy. It was an unplanned pregnancy, but she had not been using any prevention methods. With time, her complaints intensified, her functioning was disturbed, and suicidal thoughts began to emerge. Upon her application to the psychiatry clinic, inpatient treatment was recommended due to a diagnosis of depression with psychotic features; however, because neither the patient nor the family agreed to it, outpatient treatment was planned with close monitoring. However, the patient missed her control appointments, and did not use the recommended medication. On the 6th day of the 9th week of the pregnancy, she applied to the obstetrics clinic with a request of terminating the pregnancy. Psychiatric consultation was requested to evaluate her decision-making capacity.

The patient was indecisive about terminating the pregnancy. She thought that she was unfit when it came to caring for a child, that her shortcomings or faults caused her child's death, and that she would not be able to raise this baby either, and may cause its death. Her husband also changed his mind a few times and presented with an indecisive attitude, even though he previously was against termination.

Her mental status examination indicated a distressed and depressive mood, a decrease in psychomotor mobility, and persecutory delusions, such as being followed by people who have the potential of kidnapping her child; however, consciousness, orientation, perception, self-care, speed, and amount of speech were normal. She had no previous history of alcohol or substance abuse, and did not have any previous suicidal thoughts or attempts. She did not have any physical illnesses. In light of these findings, she was diagnosed with depression with psychotic features. It was decided that he individual lacked decision making capacity, and was incapable of voting on the termination of the pregnancy as one of the two spouses.

Regulations on this matter demand that pregnancies can be terminated before 10 weeks with the joint decision of the spouses. In this situation, the individual was not in a condition to approve of this procedure with her husband, and therefore, she had to be placed under custody, in addition to the permission of a civic law judge. In addition, the pregnancy

would be at 10 weeks only a day later. Therefore, it was impossible to complete the legal procedures for custody and to receive permission from the civic law judge in such a short time frame.

Therefore, even though the patient's husband had decided to terminate the pregnancy, the operation was not conducted. Hospitalization and in-patient treatment was suggested for the patient. The patient and the family agreed to the suggestion.

The patient and her husband were informed in detail about the mental disorder, its relation to the pregnancy, and treatment options. The treatment was initiated with sertraline (25 mg/day), haloperidol (2.5/day), and, when necessary, quetiapine (25 mg/day). When she was discharged four weeks later with a better clinical condition, her ambiguous thoughts about continuing the pregnancy were not completely over.

DISCUSSION

Four main factors have been determined for the systematical evaluation of decision-making capacity: 1- Understanding the options, 2- Understanding the information about the issue, 3- Comprehending the situation and the options, 4- Being able to manage all of this information in a rational way (Appelbaum and Grisso 1988, Brody et al. 2016). Before physicians perform any sort of intervention with their patients, they should evaluate whether the patient is in a condition suitable for giving informed consent (Appelbaum 2007).

A termination request from a pregnant woman with a diagnosed mental disorder leads to an ethical discussion between the patient's autonomy and free will and the physician's patient-focused point of view (Brody et al 2016). In our country, the fifth clause of the Law on Population Planning, numbered 2827, states that other than when the mother or the fetus have fatal or serious health problems, uterus evacuation can be performed until the 10th week of pregnancy, with the consent of both the mother and the father. The exceptions defined on the fifth clause of the code (Code on Practice and Inspection of Uterus Evacuation and Sterilization Services) that regulate the application of this law are presented in its amendment titled "List 2". Mental disorders included on this list are oligophrenia, chronic schizophrenia, psychotic manic depression, paranoia, substance dependencies, and chronic alcoholism.

The thirteenth clause of the same code states that to terminate pregnancies that have not passed 10 weeks, permission of the pregnant woman is required if she is of age, or permission must be given from her guardians, herself, and a civic law judge if she is under guardianship, and from her husband if she is married. The fourteenth clause notes that consent of pregnant women who lack freedom of consciousness (capacity to make autonomous decisions) due to mental disabilities would not be sought.

In the first case presented herein, when the first pregnancy was terminated in 2013, it was under 10 weeks, and the patient was forcefully hospitalized due to a manic episode. Since the patient, at that time, lacked the capacity to decide between terminating or continuing with the pregnancy, the thirteenth and fourteenth clauses of the Code on Practice and Inspection of Uterus Evacuation and Sterilization Services were applied. On the other hand, for the same patient, in 2016, the thirteenth clause was not taken into account since the pregnancy was in the 19th week. In the code, the diagnosis of bipolar disorder amounts to the psychotic manic depression, and the borderline intellectual functioning diagnosis amounts to oligophrenia. However, the medical decision on the fifth clause was that termination based on exceptional situations was not applicable since 1) the patient was in the remission phase of the bipolar disorder, 2) her borderline intelligence were not disruptive of her decision-making capacity, 3) the pregnancy did not pose a threat to the mother, and 4) serious disabilities were not expected of either the expected child or the following generations.

The second case was evaluated following the consultation request from the department of gynecology and obstetrics. It has been reported that 3-25% of psychiatric consultations are about decision-making capacity (Appelbaum 2007), and in a study conducted with 302 in-patients hospitalized due to acute neurological or infectious diseases, 48% lacked decision-making capacity (Raymont et al 2004). In our second case presented herein, the application came before the 10th week of the pregnancy, and therefore, the evaluation was made based on the 13th clause. The patient was determined to lack decision-making capacity due to depressive disorder with psychotic features; and judgment deficiencies on baby care and motherhood, resulting from depressive disorder. When the patient was seen in our hospital, it was the last day that the medical procedure for pregnancy-termination could be conducted, and there was not enough time to complete the necessary procedures for guardianship. However, both the patient and her husband were not very determined, and this ambiguity is an important indicator that the termination should not be completed.

When there is insufficient time to make an evaluation on the pregnant woman's decision making capacity, reports suggest that the decision should be made together with the potential guardian (Brody et al. 2016). Nevertheless, legal regulations in our country do not constitute a basis for such a practice, before guardianship procedures are completed. Furthermore, our country also lacks regulations for receiving faster guardianship decisions when such conditions present themselves. This is known to cause problems not only in terms of pregnancy termination, but also in other medical emergencies.

It is emphasized that when the decision-making capacity of a pregnant woman is impaired due to a mental disorder, it should first be evaluated whether the disorder is permanent or temporary, and if it is not permanent, the necessary treatment should be provided to restore decision-making capacity (Zalpuri et al 2015). In a recent case presentation, it was stated that the decision-making capacity of a disturbed pregnant woman was resumed after treatment, and therefore, the patient's autonomy was respected (Brody et al 2016). On the other hand, since the legal termination period is limited to ten weeks, the potential treatment should not exceed this time frame. Considering the low likelihood of having positive results from the oral treatment of depression before 20 days, the earlier the pregnancy or the mental disorder is detected, the more accurate the expectations about the return of decision-making capacity will be. In addition, initiating the guardianship procedures without delay would also be legally important.

Because termination of pregnancy is an elective procedure, many states in the USA allow termination until the 24th week of pregnancy, giving the physician time to treat the patient and restore her decision-making capacity (Brody et al 2016). The legal limit in our country is 10 weeks, which does not enough provide enough time to complete the treatment. Therefore, in terms of pregnant women with psychiatric disorders, contemporary regulations should give physicians more time and should allow for women with mental disorders to decide on their own pregnancies.

Decision-making capacities of pregnant women with psychiatric disorders need to be evaluated within a short time, after the department of gynecology and obstetrics ask for a consult (Babbitt et al 2014). Thus, psychiatrists must be well equipped for such evaluations, and should train their non-psychiatrist colleagues on the matter (Weinstock et al 1985). Even if the psychiatric evaluation is made quickly, patients with impaired decision-making capacities need to be evaluated by other physicians with the same care and speed as well. This can only be possible when specialized teamwork for these patients becomes widespread.

When a physician meets a pregnant woman, he should know that the person across from him is not just a pregnant woman with a fetus, but also a postpartum mother candidate and a baby. One of the fundamental ethical principles of medicine is the effort to be helpful and to keep a benefit-harm balance. This principle requires understanding what is helpful, weighing the potential benefits with potential harms, and maintaining a balance. However, in the case of a pregnant woman, it is not just one patient; and both the mother and the fetus need to be evaluated together. In most cases, the benefits are common for the mother and the baby, but sometimes, they may be in conflict. When such conditions arise, the mother and the baby should be considered as a two-unit dyad, and the decision should be made based on the largest benefit.

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