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CORRESPONDENCE

Response to "Ethical and Clinical Dilemmas in Using Psychotropic Medications During Pregnancy"

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This correspondence responds to Andrea L. Kalfoglou's "Ethical and Clinical Dilemmas in Using Psychotropic Medications During Pregnancy," which appeared in the June 2016 issue, 18(6), of the AMA Journal of Ethics.

Andrea L. Kalfoglou recently wrote in the *AMA Journal of Ethics* about the use of psychotropic medication during pregnancy. We applaud her description of some of the clinical and ethical challenges in treating pregnant women with mental illness. Her article focuses in particular on the challenges of treating depression during pregnancy. In addition to depression, however, women present for psychiatric care for a variety of metal health conditions during pregnancy. One particularly challenging scenario is the management of pregnant women with acute psychosis.

There is limited research on the effects of psychotic illness itself on pregnancy outcomes and risks to the child. Clinical experience dictates concern for serious adverse outcomes associated with not treating or discontinuing antipsychotic medication in pregnant women with severe psychotic illness. Untreated psychosis is associated with decreased compliance with health care, poor self-care, increased risk of suicide, and higher rates of drug use [1]. Additional risks of untreated maternal psychosis to the child include premature birth, low birth weight, and fetal demise [1].

The literature on fetal exposure to antipsychotic medication is similarly limited. Most studies have found no significant increase in major congenital malformations with antipsychotic medications [2, 3]. However, the US Food and Drug Administration issued a warning regarding the potential risk of abnormal muscle tone and withdrawal symptoms to newborns with exposure to antipsychotics during the third trimester [4]. The long-term risks of fetal exposure to antipsychotics remain largely unknown.

In our experience, it is not uncommon for a pregnant woman with psychosis to refuse antipsychotic medication—either due to lack of capacity for medical decision making as a result of her mental illness or in consideration of the potential risks of the medication. In some cases, involuntary civil commitment is appropriate. Although jurisdictions vary in their involuntary civil commitment criteria, most jurisdictions require that the woman, because of her mental illness, be an acute risk of harming herself or others or unable to

care for herself [5]. Jurisdictions also vary as to the legal criteria for involuntary administration of antipsychotic medication to patients who refuse or lack capacity to consent [5].

With the limited information available on the potential risks of psychotropic medication during pregnancy, clinical management requires an individualized approach, taking into consideration the scientific, legal, and ethical parameters associated with this complex scenario. Ethical dilemmas arise when two obligations conflict. From an ethical perspective, here are some of the relevant considerations.

Autonomy. The autonomy of a pregnant woman with psychosis must be considered in light of the woman's understanding of what is known about the risks and benefits of medication—to herself and her fetus—during pregnancy as well as the risks associated with untreated psychosis. With limited (and sometimes conflicting) information about such risks, it can be difficult for a woman to exercise her autonomy, even when she has capacity to consider the known information. In other cases, the woman's symptoms, such as delusional denial of pregnancy or grossly disorganized thinking, can render the woman incapable of making reasoned medical decisions. In such cases in which respect for autonomy conflicts with the imperative to avoid harm, physicians may seek consultation from other stakeholders, such as the patient's loved ones, to better understand the patient's beliefs and choices prior to her worsening psychosis.

Beneficence. The concept of beneficence is challenged in this setting, as the physician may have multiple loyalties to the woman, the fetus, and possibly others (including other patients when on an inpatient unit). Benefits of medicating a hospitalized woman against her wishes during the time of her pregnancy could come at the cost of her not seeking care in the future, if it damages her trust in clinicians. Alternately, treatment may restore a woman's decision-making capacity and result in more rapid return of her freedom from involuntary hospitalization.

Nonmaleficence. The concept of nonmaleficence is similarly relevant here. However, it can be difficult to determine whose interests prevail. Take, for example, a psychiatrist who gives a pregnant patient an antipsychotic medication on a short-term basis to reduce her paranoia about the obstetrics ward in order to facilitate her transfer to the obstetrics unit for delivery. Absent the medication, the woman would have risked having her baby in a less appropriate (and, possibly, risky environment). Can short-term breaches of the patient's interest justify the anticipated longer term benefits? Arguably, yes.

Justice. In a time of limited mental health resources, the concept of justice must be taken into consideration alongside respect for patient autonomy. Suppose that a pregnant woman with psychosis is involuntarily committed due to her inability to care for herself. If this woman refuses antipsychotic medication, one option would be to continue her

hospitalization without forcing her to take medication. However, in this scenario, her condition is unlikely to improve. She is taking resources (hospitalization) that could be used for another patient should her condition improve to the point when she could be safely discharged.

In sum, there is no "one size fits all" approach to treating women with psychosis during pregnancy, particularly when a woman refuses treatment. Some of the ethical considerations are raised here. Consistent with Dr. Kalfoglou's recommendations, physicians should aim to understand the scientific, legal, and ethical principles involved in providing clinical care in these complex cases.

References

1. American Congress of Obstetricians and Gynecologists. Use of psychiatric medications during pregnancy and lactation. Washington, DC: American Congress of Obstetricians and Gynecologists; 2008. ACOG Practice Bulletin 92.
2. Gentile S. Antipsychotic therapy during early and late pregnancy: a systematic review. *Schizophr Bull.* 2010;36(3):518-544.
3. Cohen LS, Viguera AC, McInerney, et al. Reproductive safety of second-generation antipsychotics: current data from the Massachusetts General Hospital National Pregnancy Registry for Atypical Antipsychotics. *Am J Psychiatry.* 2015;173(3):263-270.
4. US Food and Drug Administration. FDA drug safety communication: antipsychotic drug labels updated on use during pregnancy and risk of abnormal muscle movements and withdrawal symptoms in newborns. Washington, DC: Food and Drug Administration; February 22, 2011. http://www.fda.gov/Drugs/DrugSafety/ucm243903.htm. Updated May 8, 2015. Accessed June 29, 2016.
5. Weinstock R, Piel JL, Leong GB. *DSM-5* and civil competencies. In: Scott C ed, *DSM-5® and the Law: Changes and Challenges*. New York, NY: Oxford University Press; 2015:152-176.

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