

in that case

Karen is a 31-year-old woman who suffers from schizophrenia and has been treated with an anti-psychotic medication for a number of years. She is married and has with a previous partner had a child who was removed from her care due to failure to provide the necessities of life. Karen and her husband have suffered from unexplained infertility for two years and their GP has referred them to the Fertility Clinic for assessment and treatment. Karen's husband (Peter) is known to be violent towards Karen. Having become unwell, Karen visits her psychiatrist and informs the psychiatrist of their involvement with the Fertility Clinic. Karen also reveals that she does not want to have a baby, but that Peter does. The psychiatrist knows that the anti-psychotic drug that Karen is taking also causes infertility. She elects not to tell Karen about this.

commentary

Sharron Cole

Wellington Ethics Committee, Nathaniel Centre

Karen's psychiatrist will be aware of what her biological problems are and, with her re-emergent unwellness, know that her illness requires careful reassessment. In any discussion and treatment, there is an obligation to consider social, cultural and other factors that are contributing to Karen's problem. In her case, these include the knowledge that she was previously unable to care for a child and it was removed from her, secondary infertility, a violent husband and a divergence in their wishes to have a child.

The psychiatrist must be aware that beneficence, in this case treating Karen's schizophrenia, and respecting her autonomy by informing her that that this treatment may well be the cause of her infertility, may conflict with the principle of non maleficence. The knowledge that her medication is causing infertility may cause her psychological distress and anxiety. There is also the distinct possibility of further physical harm from an already abusive partner who may be angered by the knowledge that it is Karen's illness and its treatment that is probably causing her to be infertile and thus thwarting his wishes to have a child.

As voluntariness is an important factor in informed consent, Peter is a coercive factor that the psychiatrist must consider. The couple has been referred by their GP to a fertility clinic, despite the fact that Karen does not wish to have a baby. This suggests she is either afraid of Peter or there is little communication between them. It also suggests that the GP is not aware that Karen does not want to have a baby and may also be ignorant of the side effects of antipsychotic medication. Fear may cause Karen to hide her history of psychiatric illness and the medication she takes for its treatment. She could needlessly embark on infertility treatment with all the psychological and physical risks it entails. This course of action is not something that the psychiatrist ethically could stand back and allow to happen as it could and probably would cause harm. He/she would have to inform Karen that he/she would be informing the GP about her illness, her medication and its side effects.

Despite the complicating factor of a violent husband and the fear that this would engender in Karen, there is no indication that she is incompetent and that therefore she does not know what is good for her and/or needs to be protected from herself. Schizophrenia is a mental illness but it is not of itself an illness that makes Karen incompetent. There is a presumption that Karen is legally competent and that she has a right to make an informed decision.

This does not mean that she should be given a mass of what well might be overwhelming and even frightening information, with the presumption that she has both the understanding and competence to make an informed choice and decision about what she should do with respect to her medication and fertility. As well as competence and voluntariness, informed consent involves understanding. Karen is entitled to know the benefits and side effects of the medication she is taking. Until now, the medication has controlled her illness but is now less effective in doing so she will have to consider altering her medication along with other factors that are exacerbating her illness. If the antipsychotic medication causes infertility, she may see this as a desirable side effect, given her expressed wish not to have a child. She would certainly need to know if the medication might increase the possibility of foetal defect or if pregnancy might make her illness worse. Whatever decision she makes with respect to her continuing use of the antipsychotic medication and her fertility, she would need to make in the knowledge that her husband's violence towards her would almost certainly continue.

As psychiatric disorders are shaped and influenced by the social and cultural setting in which they occur, the psychiatrist needs to consider the sociocultural and other factors that are contributing to Karen's problem. It will be necessary to integrate the biological, social and psychodynamic factors of Karen's situation and with her knowledge and consent, plan and implement an effective treatment programme, including ongoing support from the appropriate health and disability services.

commentary

Gerard Kenny

Child Protection Coordinator, HealthCare Otago

It would seem that in addressing these issues there are a number of clinicians involved with a number of clinical, ethical and legal responsibilities. The major issues on the face of it appear to be the question of fertility treatment where there is previous serious concern about Karen's functioning as a parent, the situation of family violence that Karen is in, her current level of functioning, the apparently invalid consent to fertility treatment, and the apparent

withholding of relevant information from Karen by the psychiatrist.

The GP, we hope, has a longer-term treatment relationship with Karen and knows, perhaps, about the family violence. (S)he has, we hope, been working with Karen in supporting her to take positive action for her safety. The GP, we assume, is the person who has made the referral to the Fertility Clinic knowing about the previous problems of abuse and neglect.

The place of fertility treatment in this situation perhaps needs to be examined a little more closely. Fertility treatment does not just involve two people. Those referring and those providing do have a responsibility to make referral and treatment decisions in the context of reasonably predictable risk.

It may be that things have significantly changed in Karen's life since the removal of the previous child because of abuse/neglect. It may be that she has made significant changes herself, is in a more stable and settled situation and has a supportive partner. The brief scenario does not support this view. The reasonably likely outcome for any child born into this situation does need to be considered.

On the face of it would seem to be currently inappropriate to offer fertility treatment. In considering the wider context of offering fertility treatment to Karen the clinician should take into account her long term treatment for schizophrenia, the previous need to uplift a child from her care because of failure to provide the necessities of life, her current violent relationship, her current mental state, and the effects of treatment required for her mental state. The fact that she is currently described as 'unwell' needs to be explored further in terms of her ability to consent, her ability to cope with fertility treatment and her ability to cope with any subsequent pregnancy.

The psychiatrist, who is, apparently, aware that Karen is in a violent relationship has a responsibility to Karen to support her and work with her in addressing the immediate safety issues and to assist her in resolving these issues, either in terms of her getting out safely, or in terms of assisting Peter to address his own serious problems and this serious problem in their relationship. The latter course, in situations of anything other than the most low level conflict, is a high-risk undertaking which should not be entered into by anyone without specialist training.

Many clinicians feel uncomfortable or unskilled with working with women in family violence situations. Within the constraints of considerations of patient autonomy the clinician needs to be labeling violence as unacceptable and supporting the woman's motivation to get help. The clinician should be able to provide effective and safe help or ensure that she is connected to an agency, service or clinician who can.

The psychiatrist, who is the clinician who has received what appears to be new information about Karen not wishing to have a baby, bears the greater part of the responsibility for action now. She is privy to information about Karen's reluctance to have a baby. This has two major implications for Karen: firstly it should indicate to the psychiatrist that Karen is in a highly vulnerable control situation suggesting that she is at high risk from Peter, secondly it should alert the psychiatrist to the fact that there is now no valid consent for the fertility treatment. For consent to be valid it must be freely given and in this context the consent to treatment which is unwanted by Karen, but wanted by Peter, is not a valid consent.

As a colleague of the Fertility Clinic clinician the Psychiatrist has a responsibility to work with that clinician in terms of the Health and Disability Commissioner's Code of Patient Rights, in particular right 4(d) which requires clinicians to cooperate with other providers to ensure quality and continuity of service. The Psychiatrist would now seem to have a responsibility to communicate this clinical information to the fertility clinician. The management of this withdrawal of consent needs to be handled extremely carefully by both the Psychiatrist and the fertility clinic to ensure that it does not expose Karen to further risk of violence from Peter.

The Psychiatrist also has a problem in terms of information sharing with Karen. The information that infertility was a possible side effect of this treatment should have been discussed with Karen at the time of her commencing treatment with this medication for consent to have been valid. The Psychiatrist now needs to share this information with Karen so that Karen can make an informed choice in relation to her treatment. Karen will need to make a decision as to whether to continue with this current medication or discuss alternative treatments.

A valid consent to treatment must now be gained by the Psychiatrist before any treatment can be continued.

From a family safety and child protection perspective the major issues would seem to be Karen's immediate safety and the part the clinicians can play in supporting that, and the medium term support and motivation Karen will need to enhance and maintain her safety. The child protection issues in relation to the putative child remain problematic and unaddressed.

commentary

Sarah Romans

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There are two issues here from a clinical perspective, as I see this case. These are; her medication regime and the issue of her being pressurised into parenthood against her innate wishes. I suggest that these need to be considered separately.

Medication

The very brief history provided suggests that she has responded well to the older 'conventional' or 'traditional' antipsychotic drugs. This is obviously good news and she has been fortunate, as many patients have experienced such severe side-effects that they are partially or totally non-adherent to the regime which their prescribing psychiatrist recommends.

Most of the new 'atypical' or non-conventional antipsychotic drugs (the three major ones we have in NZ are risperidone, olanzapine and clozapine) do not raise prolactin, a hormone secreted by the hypothalamus in the brain. Prolactin is a hormone involved in the production of breast milk and people (both women and men) with abnormal prolactin secretion develop breast tissue, secrete milk and are subfertile or infertile. This means that these atypical drugs are much better at retaining fertility. She can be changed to one of these new agents and may well continue to do well. For such a change of drug to work she will need a good relationship with a psychiatrist and possibly a psychiatric nurse to discuss with day-to-day practical problems

There are other (claimed) advantages to the newer drugs, e.g. better impact on negative symptoms such as apathy, anergia, and low emotional responsiveness, which may also help. These new drugs are very much more expensive, a major issue which is considered by our funding agencies.

There are obviously other reasons why someone with a psychotic illness may not be fertile (problems in intimate relationships, poor understanding of the mechanics of conception, etc).

All patients need full information about the drugs that they are receiving. This includes the expected clinical benefits, side effects and time course of treatment. A well-informed patient is much more likely to be an adherent patient. So Karen should be told of the possible hyperprolactinaemia as the likely cause of her infertility. She should also be told that she has other options for her medication if *she* really does want to develop a pregnancy. She also needs careful assessment of sexually related problems she may have experienced with attention to low desire and performance.

Parenthood

Competent parenting is very difficult to accomplish where

there is a major mental illness. The sensitivity and flexibility required to relate to children is often impaired in those with major mental illness as a result of their delusional beliefs, perceptual problems or negative symptoms such as apathy, avolition or amotivation.

No woman should be asked to carry a pregnancy and commit herself to a lifetime of parenthood without her full informed consent. This does not seem to be present in the current scenario. We have the knowledge of a previous child surrendered up to care as a result (as reported) of inadequate maternal competence (though we might ask if her performance could be better with better psychiatric care). Her husband may be pressuring her to take on this additional responsibility for his own reasons. Karen's treatment team need to take the time to allow her to consider the pros and cons of a further pregnancy fully

No-one should under-estimate the huge sense of grief and loss which women with major psychiatric illness experience when they lose their children to 'care'. It usually distresses them for the remainder of their life and incidentally involves enormous social resources. This disaster must be avoided at all costs, if it can.