ETHICAL AND LEGAL ISSUES IN REPRODUCTIVE HEALTH

Legal abortion for mental health indications

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Abstract Where legal systems allow therapeutic abortion to preserve women’s mental health, practitioners often lack access to mental health professionals for making critical diagnoses or prognoses that pregnancy or childcare endangers patients’ mental health. Practitioners themselves must then make clinical assessments of the impact on their patients of continued pregnancy or childcare. The law requires only that practitioners make assessments in good faith, and by credible criteria. Mental disorder includes psychological distress or mental suffering due to unwanted pregnancy and responsibility for childcare, or, for instance, anticipated serious fetal impairment. Account should be taken of factors that make patients vulnerable to distress, such as personal or family mental health history, factors that may precipitate mental distress, such as loss of personal relationships, and factors that may maintain distress, such as poor education and marginal social status. Some characteristics of patients may operate as both precipitating and maintaining factors, such as poverty and lack of social support.

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1. Introduction

Legal systems are frequently ambivalent about the effects events may have on mental health. They recognize that physical injuries can cause pain and related mental suffering, but are guarded about recognizing suffering without injury for fear that alleged mental effects can be simulated for self-serving purposes, such as to gain compensation or relief from criminal liability. Systems have become more accommodating, however, in recognizing that pregnancy can harm mental health. In England, for instance, the Infanticide Act 1922 first recognized that post-partum mental disturbance can even cause a mother to kill the child she delivered,
and made this a much lesser offence than murder. Modern research shows that female susceptibility to neurological effects is inherent, since the reproductive hormones that determine the sex of a fetus also determine sensitivity to sex-based psychiatric conditions. The positive and negative effects of pregnancy on neurologic predispositions must always be taken into account [1].

Many legal systems now recognize a mental health indication for lawful abortion, although they may lack clarification for uniform application, such as the 2002 legal reform in Mexico City [2]. For instance, some specify rape as a separate justification, but this is usually absorbed into a general mental health indication. In Britain, for example, before enactment of the internationally reformative Abortion Act 1967, the courts had accepted legality of abortion to prevent a pregnant woman physically capable of safe delivery from becoming “a mental wreck” [3]. The 1967 Act does not address rape, but provides that abortions shall be lawful when doctors are of the opinion “formed in good faith” that continuation of pregnancy would risk injury “to the physical or mental health of the pregnant woman” [4]. Account may be taken of the woman’s actual and reasonably foreseeable environment [5].

International review shows that many laws enacted to allow therapeutic abortion as an exception from criminal liability refer simply to preservation of “health”, but some are more specific in referring to physical and mental health [6]. Since all WHO members accept its constitutional description of “health” as a state of physical, mental and social well-being, specific reference to mental health may be superfluous. More challenging is legislation that refers only to preservation of life or physical health, because by a rule of legislative interpretation, the expression of only one of two parts of a whole may imply the exclusion of the other. However, legal rules of interpretation are more often used to support lawyers’ arguments and judges’ preferred decisions than to compel particular conclusions.

2. The legal setting

In attaching considerable legal significance and consequence to physicians’ opinions, including immunity from liability for a crime some laws punish with sentences up to life imprisonment, legal systems do not require physicians to be well versed in refinements of the law. Legal focus is on the integrity of the professional processes by which physicians form their opinions and exercise their clinical judgement. That is, laws require physicians to form professional opinions in good faith, unaffected by particular ideologies or self-interest. For instance, physicians who find abortion indicated on a basis on which it may be legally authorized, but who charge fees considerably in excess of those charged for similarly managed procedures, may be suspected of opportunistically serving exploitive, self-interested motivations rather than their patients’ health interests [7]. Similarly, those who express opinions against indications for lawful abortion due to their personal dislike of the procedure, on conscientious or other grounds, [8] are failing to form opinions on their patients’ eligibility in objective good faith. As judges have explained, such physicians would have no defense to legal charges of manslaughter or criminal negligence causing bodily harm, [9] and/or to damage suits for negligence, if patients suffer harm from which physicians acting in good faith would be able to protect them.

Physicians who have convenient access to mental health professionals, particularly psychiatrists and clinical psychologists, may be expected to refer their patients for professional opinions. Criteria of convenience include timely access, and, where patients must cover costs of referral, patients’ financial means. In many circumstances, however, physicians and their patients will not have this advantage. Physicians must then form their own assessments in good faith from what they know, learn and reasonably perceive about their patients.

An obstacle to patients’ indicated care may arise when the opinion of more than a single physician is required to affirm that a legal indication for abortion is satisfied. For instance, the British Abortion Act 1967 requires the opinions of two independent registered physicians. The Act does not require that they be the first two who assess the patient, and a second concurring opinion may lawfully be found following several referrals; that is, a negative opinion does not negate a subsequent favorable opinion. Further, Section 1(4) of the 1967 Act relieves a physician from requiring an independent concurring opinion on his or her finding that “the termination is immediately necessary to save the life or to prevent grave permanent injury to the physical or mental health of the pregnant woman”.

Laws that accommodate mental health indications for abortion may lack adequate provisions to assist practitioners to apply them consistently [2]. A legal system that has not clarified the criteria for fair application of health indications for abortion may be held accountable, under the International
Covenant on Civil and Political Rights, by its monitoring body, the Human Rights Committee, as in the case of Peru [10]. When women are denied fair and dignified access to lawful abortion where it is permitted for the preservation of health, the Committee held that such denial is a form of cruel, inhuman and degrading treatment, and a denial of women’s rights to effective and timely therapy. The Committee on the Elimination of Discrimination against Women, monitoring observance of the UN Convention on the Elimination of All Forms of Discrimination against Women, has similarly condemned the unfairly restrictive practice in Namibia, where only psychiatrists are recognized as legally entitled to authorize therapeutic abortion on the basis of mental health, noting that there is only one psychiatrist in all of Namibia [11].

Courts are willing to hold governments accountable to ensure equitable access to health services, and to clarify abortion and related laws of their jurisdictions, so that health service providers and potential patients clearly understand the lawful conditions for abortion [12]. Physicians and medical associations can ask governments to clarify the scope of laws without trespassing on the functions of courts, and without prolonged costly litigation.

3. The scope of mental health

Mental health can be compromised by more than the onset of what was once described in extreme and stigmatizing language as madness or insanity. The scope of mental disorder has grown to include psychological distress or mental suffering associated with loss of personal integrity and self-esteem caused, for instance, by pregnancy following rape or exploitive incest bordering on rape, and, as the Human Rights Committee recognized, diagnosis of severe fetal impairment such as anencephaly [10]. Some laws specifically identify diagnosis of severe fetal impairment as an indication in itself for lawful abortion, but the Human Rights Committee made it clear that the natural reaction women may experience on learning this diagnosis can satisfy the mental health indication for abortion. Legal and ethical challenges arise, however, when distressed women seek abortions because fetoscopy or ultrasound discloses relatively minor, possibly curable fetal conditions such as club-foot or cleft lip.

Social circumstances can also be relevant to a physician’s finding in good faith that pregnancy presents a threat to a woman’s mental health. In some cultures, unmarried pregnancy places women in reasonable fear of familial and/or social ostracism, and significantly reduces prospects of marriage and of their own future family life. It may also create fear of subject to physical violence, and even of death where so-called family “honor” is implicated. The same may apply regarding pregnancy outside marriage, and in some settings across racial or religious demarcations. This recognition conforms to the WHO conception of “health” as including mental and social well-being.

A long-standing but perhaps controversial mental health indication for abortion is a distressed woman’s mention of suicide, [13] which her physician may have a legal duty to act to prevent. Coroners’ verdicts of suicide almost invariably add “while the balance of the mind was disturbed,” associating suicide with mental imbalance. There is certainly a history of pregnant women’s suicides, although the explanations that some families have offered of suicide, such as by falls from heights, may have masked families’ violent reactions to pregnancies seen to dishonor them. Despite this history, however, threats of suicide revive suspicions of mental conditions being simulated for utilitarian or manipulative ends. [14] A further concern is that while risk of pregnant patients’ genuinely suicidal motivations may properly induce physicians to approve abortion, popular acceptance that pregnant women are disposed to irrational, emotional or impulsive self-destructive behavior demeans women as competent, reasoning decision-makers. Nevertheless, when physicians in good faith fear that pregnant patients may endanger their own lives, they may approve abortion on the indication of saving life or of preventing grave permanent injury to physical health.

It is a question of professional judgement to what extent physicians should take into account the prospective mental effects on women not just of pregnancy and delivery, but of childcare. It has been seen that laws may recognize post-partum depression or mental disorder, and that, for instance, the 1967 British abortion law provides that “[a]ccount may be taken of the woman’s...reasonably foreseeable environment” [5]. Some legal systems explicitly permit abortion on the ground of women’s prospective inability to care for children. For instance, the Criminal Code of Ethiopia, revised in 2004, permits abortion “where the birth of the child is a risk to the life or health of the mother” and “where the pregnant woman, owing to a physical or mental deficiency she suffers from, or to minority, is physically as well as mentally unfit to bring up the child” [15].
4. Mental health assessment

Both psychiatrists and, when they are not reasonably available, non-psychiatrist physicians may conduct assessments of women requesting abortion to determine whether they satisfy mental health indications provided by law. Refinements of particular legal provisions are subordinate to physicians’ conscientiously formed clinical judgment. It has been observed that “[l]egal regulation of access to abortion services is determined by whether doctors are acting in ‘good faith’ when they consider the questions set out in the legislation, not by direct consideration of those questions” [16]. However, physicians are not free to be arbitrary, subjective, or idiosyncratic, but must make an effort in their circumstances to act within professional standards of assessment.

Components of assessment are usually the patient’s current and previous symptoms of mental disorder, including information about past psychiatric and medical history and problems in her family. Individual coping strategies, such as how well the patient has dealt with sources of stress, particularly in the past year, and her overall level of functioning must be evaluated. Social and any occupational features of the patient’s history may link mental health symptoms to events in her life. Attention should also be given to moral values in her socio-cultural community, including its religious orientation and practices, to assess the impact on her mental condition of her cultural beliefs, and of possible conflicts between her cultural values and her perception of her social interests.

The model commonly applied to conceptualize causes of significant mental health problems is the biopsychosocial model, described by Dr. George Engel in 1980. [17] This explains how suffering, disease and illness are affected by different levels of biological organization, from the molecular—genetic level to the societal. [18] This model serves to group the likely causes of mental disorder into vulnerability, precipitating and maintaining factors:

- **Vulnerability factors** are the more remote considerations that affect general risk, including genetic inheritance indicated by the patient’s personal and family psychiatric history, early childhood experiences such as neglect and abuse, multiple shifting of school or home, education, and certain personality characteristics, such as impulsiveness. These factors set the background from which a disorder may emerge, showing different individual and family susceptibilities to develop psychiatric disorders.
- **Precipitating factors** are those that occur more immediately, shortly before possible onset of a disorder, such as bereavement, termination of a significant intimate relationship, or loss of employment. An unwanted pregnancy and surrounding events, such as sudden separation from a partner, can create factors that could precipitate mental disorder.
- **Maintaining factors** include chronic difficulties, such as poverty, marginalized social status, lack of social support, and frustration in obtaining appropriate services, which set a disorder on a chronic course. Some characteristics can function as both precipitating and maintaining factors, such as poor social support and poor education.

5. Operationalizing the mental health indication

The mental health indication for abortion can be applied to include three operational categories.

a) **Acute suicidality.** Acute risk of suicide is the clearest criterion of the mental health indication for abortion. Typically, this risk is assessed by determining whether the patient has immediate intent to harm herself, and whether she has a specific plan in mind. As has been seen, such a plan or intent satisfies laws that allow abortion only where pregnancy is found to be a risk to life. However, most laws allow a health indication that falls short of a risk of imminent death, so that account can be taken of risk of morbidity. The mental health indication therefore also includes the following categories.

b) **Current serious and/or chronic mental illness.** Serious and/or chronic mental illness, including major depression, schizophrenia, and bipolar disorder (formerly known as manic depression) can sometimes impair ability to function in various capacities, including as a parent. Serious mental illnesses are diagnosed according to criteria defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association, [19] or the International Classification of Diseases, produced by the WHO. [20] When a woman is found to be currently suffering from a serious and/or chronic mental illness, her parenting capacity should be evaluated in light of her own assessment, as well as that of other adequately informed sources, where appropriate, such as her partner.
When a woman so affected seeks abortion, her physician must address her capacity for informed consent. Careful evaluation should assess whether delusions or paranoid feelings are affecting her judgement, [21] and whether she has the ability to understand her condition and options. Before pregnancy is terminated, the patient’s psychiatric condition should be stabilized with medication, which usually can be accomplished within a few days, so that she is able to make the decision that seems best to her.

c) Risk of future negative mental health outcomes.

This criterion for abortion refers to situations in which a woman is not currently mentally ill or suicidal, but there is reason to believe that continuation of pregnancy would risk her future mental health, due to vulnerability, precipitating, and/or maintaining factors (Section 4 above). Risk might arise when pregnancy has resulted from rape, when harmful fetal conditions are diagnosed, and when other pregnancy-related factors or adverse social circumstances appear so distressing as to be liable to cause depression or other psychiatric illness. Similarly, adolescent pregnancy is often associated with risk of future negative mental health consequences, as illustrated in the following example.

6. Case example

Ann, aged 17 and seven weeks pregnant, asks her family doctor for an abortion. She left school ten months ago, and has since worked as a waitress. She lives on her own, and became pregnant in a short-lived relationship, now ended, with an older married man. Ann has an older sister and a younger brother, all raised by their mother after her father left the home when Ann was six. She suffered depression at age 14 following the death of her father’s mother, to whom she was very close, especially after her father left, and was treated with medication for several months. Her mother worked long hours as the family was poor, and the children were often left to fend for themselves until she returned home late in the evening. Ann’s mother suffered from intermittent depression and was prescribed antidepressant medication and benzodiazepines for sleep disorder and anxiety.

Ann had been an anxious child, eager to please adults. A neighbor friend of her mother’s had sexually abused her when she was eight years old by genital fondling over a four month period, leaving her confused and uncertain about sexuality and her own wishes. She has had no other sexual involvements except that which had resulted in her pregnancy. She sees herself as lacking in confidence, and as a nervous person who watches life passively from the sidelines. When faced with a problem, she typically ruminates unproductively and becomes anxious and uncertain. She has two close female friends, but has not told them, nor her mother, sister or brother, about her pregnancy.

6.1. Analysis

This young woman presents several clear risk factors for the onset of major depressive disorder, including vulnerability factors (such as her personal and family history of mental illness, disruption of secure family bonds, history of childhood sexual abuse, low self-esteem, incomplete education, and immature coping strategies), precipitating factors (such as unwanted pregnancy and a recently terminated relationship), and maintaining factors (such as poor economic prospects and little social support).

The disability associated with depressive illness is now well documented, and can last for several months beyond resolution of the depressive syndrome itself. In addition to personal role impairment, many patients experience negative reactions from family members and others in social, educational and, for instance, employment relationships as a result of the patients’ depression, all of which further compounds the impact of their episode. Although Ann is not currently acutely suicidal nor suffering a serious, chronic mental illness, the multiple risk factors she presents for psychiatric disorders indicate clear risk for future negative mental health outcomes. The criteria for the mental health indication for abortion, as applied above (see Section 5), would be met in this case.

7. Conclusion

In many jurisdictions that have a mental health indication for abortion, it is often applied inconsistently and with a lack of transparency, causing unfair access to lawful services. Where grounds for lawful abortion are applied inconsistently, ministries of health have legal obligations under human rights principles to provide guidance to ensure fair and transparent access. Human rights principles that require governments to ensure fair access include women’s rights to equal application of the law, equal access to lawful health services, and the right to be free from inhuman and degrading treatment. In addition to governmental obligations under national constitutions and human rights laws, the medical profession has ethical responsibilities
to ensure that practitioners provide equitable access to lawful care.

Accordingly, guidelines for the mental health indication for abortion are required for prudent physicians to observe and for women considering abortion to understand. Guidelines may accommodate clinical judgement by indicating an open-ended list of pregnancy-related risk factors. Risk should be evaluated with respect for the decision a woman makes, bearing in mind that, should she opt for a procedure for which she is legally eligible, her health would be protected by its skilled performance. Guidelines could outline three categories under which criteria for the mental health indication for abortion would be met; that is, acute suicidality, current serious and/or chronic mental illness, and risk of future negative mental health outcomes. Determination of a woman’s eligibility under any of these categories can be easily and objectively assessed by a physician in good faith with little or no psychiatric specialization.

References