FRONTLINE PERSPECTIVES

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Maternal Request for Cesarean Delivery Complicated by Schizophrenia with No Identifiable Legal Next of Kin. How Does an Obstetrician Proceed?

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Abstract

Obstetricians serve as advocates for women during one of the most demanding times in their life: pregnancy. In this case, we present a gravid female who required long term hospitalization for schizophrenia, lacked medical capacity, requested a cesarean section, desired adoption for her infant, and had no identifiable next of kin. Due to the complexity of this case and the need to gather robust information to guide patient management, a literature search was done and we realized how little information is available to guide obstetricians in cases such as this.

This article details the hurdles that the providers had to overcome to ensure the patient's requests were appropriately considered and to ensure her medical decisions were placed into the hands of the appropriate person(s).

Key Words: Schizophrenia, Next of Kin, Medical Decision-Making Capacity, Cesarean Section

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Case

J is a 31-year-old G3P2002 at 22 0/7 weeks gestational age with medical history of schizophrenia, morbid obesity, type 2 diabetes mellitus, and chronic hypertension, who presented to OB triage via Emergency Medical Services for delivery as she believed she was 9-months pregnant. The patient was evaluated and had no acute obstetric problem. However, she was delusional and was not felt to be safe for discharge. The patient was being managed as an outpatient by her Assertive Community Treatment (ACT) team, which is an interdisciplinary team composed of medical, behavioral health, and rehabilitation professionals who work to provide for the needs of individuals with severe mental illness in an outpatient setting to reduce hospitalization.[1] After discussions with her ACT team and hospital psychiatric team, the decision was made to involuntarily commit the patient to the psychiatric hospital for further management and stabilization.

Upon admission to the psychiatric hospital, transfer to a perinatal psychiatric hospital was requested but was denied. She was well known to the hospital psychiatric team due to multiple prior inpatient admissions. At the time, she was noted to be tangential, disorganized, and delusional, with poor insight and judgement. Her antipsychotic regimen was altered to attempt to improve her mental functioning and the obstetrics team followed peripherally to ensure she received standard obstetrics care during her admission, given her comorbid conditions. She received appropriate antenatal fetal surveillance and remained admitted to the mental health hospital throughout the remainder of her pregnancy and delivery. She was subsequently readmitted to the mental health hospital after delivery.

Discussion

Schizophrenia is a chronic psychiatric disorder affecting up to 1% of the population and is characterized by delusions, hallucinations, disorganized speech, disorganized or catatonic behavior, and negative symptoms.[2] Given the nature of the disease, it can be quite difficult to achieve remission, as acute episodes are common and the disease itself can be debilitating.[3] Our patient's disease was chronic with frequent acute episodes requiring inpatient stabilization. Upon admission, she was managed on monthly aripiprazole injections, and additional oral risperidone, trazodone, and hydroxyzine were added in an attempt to improve the patient's symptoms.

During her hospitalization, the patient repeatedly voiced a strong desire for delivery via cesarean section and to place the infant up for adoption after delivery. Unfortunately, the patient had

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no known next of kin and the father of the baby was unknown. A myriad of medical and legal complexities ensued. Does she have capacity to make medical decisions for herself and her fetus? Should we honor her request for a cesarean section? Who is her medical decision maker? Can she place the infant up for adoption? This article explores the hurdles that the psychiatric, obstetrics, and anesthesiology teams had to overcome and offers suggestions should clinicians encounter similar cases in the future.

Medical capacity refers to an individual's ability to provide consent to healthcare related treatment.[4] Capacity is determined by a clinician and defined in terms of four basic criteria: understanding, appreciation, reasoning, and expression.[4,5] (Competence is a separate legal term and in our state it can only be decided in a court of law.) Our patient's psychiatric team stated she did not have capacity to make medical decisions; however, she had no identifiable next of kin. The hospital ethics committee was consulted and recommended appointing guardianship. If guardianship could not be established, the medical decision maker would become the physician(s) as per the law in our jurisdiction.

In adults, the default surrogate decision maker is the next of kin. Each state has its own priority list for next of kin. The typical progression includes spouse/domestic partner, adult child, parent, sibling, other relatives, and close friends. If none of these people are identified, a court-appointed guardian or physician may be deemed as the patient's medical decision maker. Given our patient's situation, multiple attempts were made by the psychiatric hospital providers to obtain a legal guardian.

A guardian is authorized by the clerk of superior court to be the substitute decision maker for an adult who is no longer able to make decisions for themselves. There are multiple types of guardianship with different terminology depending on state of residence. An appointed guardian is typically the legal next of kin; however if unavailable, volunteers or government agencies can be deemed a legal guardian. To obtain guardianship, a petition is submitted and the clerk of court will schedule a hearing. [6] In our case, emergency/temporary guardianship was requested on two occasions with the county. The mental health providers wrote detailed letters to the county pleading for an outside guardian considering the potential implications of her requests. Department of Social Services (DSS) representatives met with the patient on each occasion to determine if they could move forward with the petition to the court; however, our patient "did not meet criteria for guardianship" and both applications were denied. They felt it was best to readdress guardianship in the postpartum period

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when they could be certain her pregnancy was not affecting her disease. On review of the literature, it appears as though this process is either declined or prolonged in many situations, and leaves many patient's medical decisions in the hands of providers across the country. [7]

Conclusion

As our patient had no legal next of kin and guardianship applications were denied by the county, we (the obstetricians) became her medical decision makers. We consulted the ethics committee who helped us determine how to proceed under basic ethical principles (autonomy, beneficence, non-maleficence) considering her risk profile and requests. Our risk management protocol stated that two attending obstetricians were required to sign her surgical consent form should we proceed with surgery and two attending anesthesiologists would be required to sign her consent for anesthesia.

Our patient had two prior successful vaginal deliveries, however, she requested primary cesarean section. Although no route of delivery comes completely without risk to the mother and/or fetus, arguably, vaginal delivery in a previously parous female has a safer risk profile than cesarean section, especially in a morbidly obese female. However, 2.5% of births in the United States are via cesarean delivery on maternal request. [8] As an obstetrician, when a woman requests cesarean delivery, it is imperative to consider and discuss her particular surgical risk factors and explore her reasoning for the request. If the patient still desires cesarean delivery after extensive counseling, one should proceed with cesarean delivery. Although it is one of the most common surgical procedures performed annually, recovery is longer, and there is a higher risk of bleeding and damage to surrounding organs. Our patient voiced constant discomfort with pregnancy and requested cesarean delivery because she felt the pain of labor would be traumatizing. As two attending physicians from each department were deemed to be the patient's medical decision makers, her requests, combined with optimal management were not easy decisions to make. Despite her risk factors for intra- and post-operative complications, including morbid obesity and difficulty with pain management, she persisted in her desire. Given a diagnosis of chronic hypertension, the patient required delivery between 38 0/7- 39 6/7 weeks.

Several multidisciplinary conferences ensued featuring obstetricians, psychiatrists, nursing staff/administrators, anesthesiologists, social workers, ethics committee members, and legal representatives until a unanimous decision was made regarding her care. Ultimately, we concluded

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that an induction of labor would not be tolerated well by the patient. Anesthesiology and psychiatry did not feel the patient could tolerate epidural or spinal anesthesia; therefore, a cesarean section was performed under general endotracheal anesthesia. The procedure was uncomplicated overall. During the procedure her gravid uterus was noted to be rotated approximately 90 degrees to the left, raising the question of whether this could have contributed to some of her discomforts and prompted her request for a cesarean section.

After delivery, DSS took immediate custody of the infant and placed the infant up for adoption. The patient declined any interaction with the neonate after delivery. The patient's pain was well controlled in the post-operative period, using a patient-controlled analgesia pump. She was discharged back to the psychiatric hospital on post-operative day 3. She was seen on post-operative day 10 by the obstetricians and voiced her satisfaction with her care. Her pain was well controlled. She remains admitted to the psychiatric hospital and the team is hoping to find placement in a long-term facility or group home for the future.

The goal of care with any patient is to advocate for them by recognizing their autonomy, while also practicing under the principles of beneficence and non-maleficence. Unfortunately, our case describes a situation where our pregnant patient was deemed to not have medical capacity, had no legal next of kin, and after multiple failed guardianship requests, her medical decisions were placed into the hands of her physicians. Our institution hosted several multidisciplinary conferences to discuss this patient's case extensively and no decision was made solely by one provider. The team approach allowed for extensive discussion and allowed each member to voice their concerns and opinions to ensure optimal care for patient, fetus, and subsequently, the neonate.

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