

Psychotic Denial of Pregnancy: Legal and Treatment Considerations for Clinicians

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The authors examine the legal questions raised by the involuntary medical and psychiatric treatment of a patient with psychotic denial of pregnancy. A case is presented, and psychotic denial of pregnancy is defined. Legal cases are reviewed that set precedent for state intervention on behalf of either the pregnant mother or the fetus when the mother refuses care. Included are specific cases that have a bearing on the rights of pregnant women with co-morbid mental illness. A distinction is made between cases in which the mother is competent versus incompetent to make treatment decisions, and particular attention is paid to California law. The authors conducted systematic Westlaw and LexisNexis searches of relevant case law and legal precedent. Laws that address the rights of pregnant women are complex, and courts have allowed medical interventions against objection in cases of both competent and incompetent mothers. No clear legal precedent was found to guide decision-making in the specific case of a woman with psychotic denial of pregnancy. The principles of substituted judgment and best interest may help guide clinicians in making decisions about the treatment of pregnant patients in the absence of clear legal precedent.

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While the laws pertaining to involuntary psychiatric hospitalization remain clear in many circumstances, understanding and applying these laws became particularly murky in the case, reviewed herein, of a psychotic woman who denied her pregnancy. A multidisciplinary team, comprised of social workers, nurses, obstetricians, and psychiatrists, was involved in the evaluation and treatment of the patient. As the psychiatrists involved, the authors of this paper were particularly interested in examining the decisions made in regard to her mental health care.

While reviewing the steps that were taken, we recognized that the decisions made regarding the patient's mental health were informed by the patient's advanced intrauterine pregnancy. The treatment

team was faced with questions of how and when physicians should intervene in cases of pregnancy and co-morbid mental illness.

Given the legal questions that this case introduces, the purpose of this article is threefold. First, we present a case of psychotic denial of pregnancy and define denial of pregnancy. Second, we present legal cases that have set precedents for court-ordered intervention on behalf of a pregnant mother or fetus, focusing on cases of women with co-morbid mental illness. Third, we examine legal cases that define the rights of a fetus.

Case Facts

The patient was a homeless woman who presented to a free clinic, self-reporting a history of schizophrenia, requesting an albuterol inhaler for an asthma exacerbation, and complaining of stomach pain. Noting that she appeared visibly pregnant, clinic staff obtained her permission for a urine pregnancy test, which confirmed the pregnancy. The patient denied the validity of the test and began to express

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bizarre and paranoid thoughts. Staff transferred the patient to a hospital for obstetric care, where she allowed a bedside sonogram that confirmed a third-trimester, viable, intrauterine pregnancy. She denied that the ultrasound showed a fetus, calling it a “phantom pregnancy,” and refused further evaluation. The obstetrics service sent her to the psychiatric emergency service, where the psychiatrist placed her on a 72-hour involuntary hold for grave disability, or the inability to provide and execute a reasonable plan for self-care on the basis of a mental illness, and admitted her to the inpatient psychiatry unit.

Although she was generally cooperative and pleasant with staff on the psychiatry unit, she became irritated and suspicious when the subject of her pregnancy arose. She explained her enlarged abdomen as a “paranormal” phenomenon that had been “projected” onto her and as a prolonged reaction to eating granola the month before. She reported having been pregnant in the past as a result of “switching bodies with another woman” and “swapping bodily fluids.” She also recounted having had a child removed from her custody by the child protective service system many years earlier.

The patient denied auditory or visual hallucinations and was noted to have above-average intelligence. Her verbal communication was characterized by some tangential speech, but when redirected, her thought process could be linear. She refused to allow the treatment team to contact others for collateral information. She refused laboratory work, vital sign monitoring, obstetric care, and medications, including prenatal vitamins. She spoke with a nutritionist, who learned that for several weeks before admission she had been eating one meal per day and had not been meeting the nutritional requirements of pregnancy. The psychiatrist then placed the patient on a 14-day hold for grave disability, based in large part on the nutritional assessment. The patient subsequently lost her probable-cause hearing and a second hearing that determined her right to refuse psychotropic medications. She thus remained on the inpatient psychiatry unit and was administered psychotropic medication.

Psychotic Denial of Pregnancy: Definition and Epidemiology

In 2002, Wessel and Buscher¹ defined denial of pregnancy as “a woman’s lack of awareness of being pregnant.” In 2006, Beier *et al.*² elaborated that de-

denial of pregnancy is a “subjective unawareness of pregnancy until at least week 20 of gestation.” Such cases were further classified as denied pregnancy or concealed pregnancy and a smaller group who attempted to forget their pregnancies. In this classification scheme, psychotic denial of pregnancy was considered a subset of denied pregnancies. For the purposes of this article, the authors define psychotic denial of pregnancy as pregnancy denied due to impairment caused by psychosis.

Despite clear definitions of the phenomenon of denial of pregnancy, the epidemiology of psychotic denial of pregnancy remains difficult to elucidate. Wessel and Buscher¹ revealed one case of denied pregnancy in 475 deliveries (95% confidence interval, 370–625). This study was notable as the first published population-based frequency ratios regarding denial of pregnancy. The rate of “pervasive denial,” referring to women who did not realize they were pregnant until they went into labor, was found to be 1:2,455 (95% confidence interval, 1,429–5,000). As Beier *et al.*² later pointed out, the general ratio of 1:475 is comparable with frequency calculations of nonepidemiologic studies with a larger sample of patients. This finding indicates a similar frequency of denial of pregnancy across different sociodemographic regions.

Legal Rights of Pregnant Patients

While the prevalence of denial of pregnancy is unclear, equally unclear are the laws that apply to a pregnant woman’s personal rights. For example, 17 states provide statutory exceptions to the living will or health care proxy statutes that render advance directives automatically ineffective if the patient is pregnant.³ Another 16 states render the living will or health care proxy inapplicable in a variety of circumstances, ranging from the possibility to the probability that the fetus will develop to a live birth.³

A woman’s pregnancy raises questions of ethics and the law, with respect to her treatment. As physicians, our goal is to remain unbiased and provide care that is within medical, ethics-related, and legal standards in every case, particularly in complicated instances. Herein, we outline our best effort at reviewing relevant case law and conceptualizing the challenges posed by the case already described.

Framework of Legal Analysis

The first question with which we are faced in this case is whether there are grounds to hold the patient for psychiatric reasons—that is, what is the legal basis for involuntary commitment?

According to California law, a person can be committed involuntarily for psychiatric care due to a mental illness if she falls into one of three categories: grave disability, danger to self, or danger to others. The patient was committed on the basis of grave disability, due at least in part to the nutrition evaluation. Yet, could we consider her as a danger to self, given the medical risks of a pregnancy that remains unmonitored?

In the case of psychiatric commitment in California, common interpretation is that the danger to oneself must be deemed imminent. Statistically, psychotic denial of pregnancy most often presents in the third trimester. Such denial carries with it a risk of precipitous labor that is of great danger to the mother.⁴ In the 20th century, third-trimester psychotic denial was deemed an acute psychiatric emergency (i.e., imminent), thereby justifying commitment to a hospital.⁵ Solely on that basis, many physicians have chosen to commit psychotic patients involuntarily whose pregnancy is in the third trimester. The courts have historically upheld these commitments.

What about the concept of danger to others? As we examine whether grounds were established to hold the patient involuntarily as a danger to others, we cannot ignore both the current and historic debate over fetal rights. This subsequently raises a complex array of issues, mostly steeped in the debate about abortion. The courts have approached the rights of fetuses from various angles. Some have focused on civil commitment for psychiatric reasons to protect the health of the unborn fetus, and other courts have focused on criminal detention.

Although the question of whether the patient may be held is of primary importance, simply confining her to the hospital does not, in fact, address whether she should receive prenatal care that she does not want. Historically, doctors and courts have intervened in the case of a pregnant woman in need of medical care on two bases. The first category of interventions we outline considers the health of the mother, and the second category considers the health of the fetus. As we review interventions on behalf of

the mother, we can examine these interventions on the basis of the mother's competence. We can use the same analysis regarding interventions on behalf of the fetus. In the following sections, we outline case law for such interventions in an attempt to find the legal principles that can help guide clinicians in a very complicated situation.

Intervention on Behalf of the Mother When the Mother Is Incompetent to Make Treatment Decisions

To intervene on behalf of the mother, one must first answer the question of whether the mother is competent or incompetent to make treatment decisions, henceforth referred to as simply competent and incompetent, respectively. The 2002 edition of the *McGraw-Hill Concise Dictionary of Modern Medicine* defines competence as “a legal term for the capacity of a person to act on his/her own behalf; the ability to understand information presented, to appreciate the consequences of acting—or not acting—on that information, and to make a choice” (<http://medical-dictionary.thefreedictionary.com/competence>). In the case of intervention on behalf of the mother in which the mother is competent, the law allows the pregnant mother to make choices about her own health.

Substituted Judgment

In the case of intervention on behalf of the mother in which the mother is incompetent, as in the present case, the laws of substituted judgment come into play. The legal concept of substituted judgment looks to the individual and attempts to determine what she would do in a particular situation if she were competent. This requires an understanding of the individual before incompetency and does not depend on what others involved think should be done. The courts made this point in *In re A.C.* in 1990.⁷ In this case, a woman who was 26 weeks pregnant had cancer and was unconscious. Her doctors filed a petition requesting permission to perform a cesarean delivery. During the court proceedings, however, the woman briefly regained consciousness and seemed to have mouthed words to the effect that she did not want the operation performed. However, the trial court granted the petition, the operation was performed, and both mother and child died. The District of Columbia Court of Appeals reversed the trial court's judgment, which had given the hospital per-

mission to perform a cesarean section on a comatose woman, and the case was remanded. The court held that if a patient is incompetent or otherwise unable to give informed consent to a proposed course of medical treatment, then her decision must be ascertained through the procedure known as substituted judgment.

Best-Interests Standard

An additional concept, the best-interests standard, became relevant in the case of D.R. in 1999 (*D.R. by A.F. v. Daughters of Miriam Center for the Aged*).⁸ A woman, deemed incompetent, sustained severe brain damage as a result of the improper administration of anesthesia during the delivery of her third child. Years later, while living in a convalescent home, she was found to be in her 21st week of gestation, pregnant by an unknown male. The plaintiff in the case wanted the woman's pregnancy terminated. Based on the court's personal interview with the pregnant woman, medical reports, and testimony, the court held that she was not competent to make a decision concerning procreation. Of note, no testimony was offered as to what the pregnant, incompetent woman would have done under the circumstances if she had made the decision. The pregnant woman never contemplated the situation when she was competent. Because no testimony was forthcoming, the best interests of the pregnant woman were examined. Doctors felt that abortion was a higher risk to the mother than carrying the pregnancy to term. The court ultimately held that where a person is incompetent and no testimony is offered as to what she would have done if competent (i.e., no substituted judgment), doctors are able to determine the best interest of a patient.

In a third case that examined the pregnancy of an incompetent mother, *In re Boyd*, the District of Columbia Court of Appeals held that when a patient before incompetence objects to medical care and shows no evidence of vacillation, pursuant to the substituted-judgment concept, the court should conclude that the individual would reject medical treatment.⁹

Notably, no legal precedent stands for the use of the substituted-judgment doctrine to permit a significant intrusion on the body for the benefit of another. It has been suggested, however, that fetal cases are different because, in theory, a woman who has

chosen to become pregnant presumably wants to produce a viable child.

Intervention on Behalf of the Fetus When the Mother Is Competent

***Parens Patriae* and Police Power**

Two principles that guide intervention on behalf of the fetus have been argued in the courts. The first is the concept of *parens patriae*, through which the state can act as father of the people (i.e., the state can usurp the powers of parents in the interest of protecting the child). This concept has been used to argue that the courts should be able to take custody of a fetus whom the court views as endangered by the mother's behavior.

The second principle is the concept of police power, which permits the state to act to protect the community from a dangerous person. To use such an argument to intervene, the state must demonstrate that the fetus constitutes a legally recognized other at risk of injury because of the pregnant woman's behavior. The argument then centers on whether the fetus is a third party and thus deserving of rights.

If the state plans to intervene on behalf of the fetus, the question of the mother's competence is very relevant. In the case of a competent mother, the examples set forth by substance-abusing pregnant women are quite relevant.

In cases of competent women who abuse substances, different courts and states have drawn various conclusions. In some cases, criminal charges have been brought against the mother on the basis of both child abuse/neglect and manslaughter/murder.

Intervention on Behalf of the Fetus

Child Abuse or Neglect by a Competent Mother

Several states have sought to criminalize women who abuse substances while pregnant, intervening on behalf of the fetus despite the mother's competence. The success of these cases has varied from state to state. In 1990, a woman in Wisconsin was prosecuted for felony child abuse when she self-presented at four months' gestation to the hospital for treatment of injuries sustained from domestic violence and had an elevated blood alcohol level.¹⁰ In addition, in South Carolina in *Whitner v. State*,¹¹ the court upheld a conviction for child abuse based on the defendant's drug use during pregnancy, finding

that a viable fetus is indeed a child within the meaning of the child abuse and endangerment law.

Conversely, other states have upheld the mother's right to abuse substances while pregnant if she is assessed as competent. For instance, in *State v. Gray*,¹² the Ohio Supreme Court held that Ohio's child endangerment statute did not allow the state to prosecute a mother for child endangerment on the basis of substance abuse *in utero*.

Manslaughter or Murder of the Fetus by a Competent Mother

In some states, criminal prosecutions have reached the more severe level of charging a mother with manslaughter when a fetus dies of drug-related complications. A grand jury in Illinois in 1989 did not indict a defendant on a manslaughter charge when the defendant used cocaine and the infant subsequently died of a cocaine-related complication. Yet, in South Carolina in 2003 in *State v. McKnight*,¹³ the state supreme court affirmed a homicide by child abuse conviction and upheld a 20-year sentence of a defendant who had given birth to a stillborn child in the context of substance abuse.

In the highly political case of *State v. McKnight*,¹³ issues of mental illness and poor access to health care resources arose. Regina McKnight was a homeless, African-American, mentally deficient woman with an IQ of 72, who was pregnant and addicted to cocaine. She was charged with murder when her child was stillborn. The court rejected McKnight's arguments that no sufficient evidence showed causation or *mens rea*.³ Opponents within and outside the state condemned the court's decision, arguing that the state was unfairly singling out a poor, African-American woman and had failed to address the relevant problems of addiction and lack of health care access.³ Critics charged that threats of criminal prosecution would drive pregnant, substance-abusing women away from treatment out of fear that they would lose their newborns or be imprisoned. Alternatively they called for the courts to provide these women with social and economic support and effective drug rehabilitation.³

The argument for intervention on behalf of the fetus in the case of a substance-abusing mother continues. In Hawaii in 2005 in *State v. Aiwohi*,¹⁴ the state supreme court, ruling that a fetus was not a person, overturned a manslaughter conviction in a case in which a defendant used methamphetamines while pregnant, causing the death of a two-day-old

infant. However, in Utah in 2004, a defendant using cocaine and alcohol gave birth to one stillborn and one healthy baby, and the defendant was charged with murder. The charges were ultimately dropped because of the defendant's mental state.

Civil Commitment for Substance Abuse by a Competent Mother

Currently, 34 states permit men and women to be civilly committed for alcohol and drug abuse when their behavior due to intoxication or dependence imminently threatens themselves or others.¹⁵ Three states have taken this concept further by authorizing involuntary civil commitment of pregnant, substance-abusing women to protect the health of the fetus.¹⁶

In reaction to a case in 1997 (*State ex rel. Angela M.W. v. Kruzicki*),¹⁷ in which the Wisconsin Supreme Court held that the defendant could not be compelled to participate in an inpatient drug treatment program, Wisconsin authored the first state statute permitting the civil commitment of a pregnant woman to protect the health of her fetus.¹⁸ This statute allows for commitment of a pregnant woman if the health of the fetus is in jeopardy due to her alcohol and drug use. Furthermore, the statute amended pre-existing law to include "unborn children," defined as "a human being from the time of fertilization to the time of birth."¹⁹ Minnesota has a similar statute, permitting the involuntary civil commitment of pregnant women who are dependent on illegal drugs, not including marijuana or alcohol.²⁰ The statute mandates health care providers to report to state agencies if they know or have reason to believe a woman is pregnant and has used a controlled substance during pregnancy. Finally, in South Dakota, another state statute permits the involuntary emergency civil commitment of pregnant women who abuse alcohol or drugs.¹⁶ In this statute, the court can place a pregnant woman in custody for the duration of her pregnancy if she is found to be abusing alcohol or drugs.

A Competent, Sober Mother Who Refuses Medical Treatment

In the case of a competent sober mother who refuses medical treatment, the law is equally complex. In rare cases, the courts have overridden competent women in the interest of protecting the third party, the fetus. The District of Columbia Court of Appeals ruled in 1990 in *In re A.C.*,⁷ that any person has the

right to make an informed choice, if competent to do so, to accept or forgo medical treatment. The court stated, "a fetus cannot have rights . . . superior to those of a person who has already been born," thereby holding that a pregnant woman has the right to control her medical treatment, even when her decision affects the health of the fetus (Ref. 7, p 1244).

While recognizing the woman's right to accept or reject medical treatment, courts have held that such a right is not absolute, recognizing four interests that may involve the state as *parens patriae*: preserving life, preventing suicide, maintaining the ethical integrity of the medical profession, and protecting third parties. Yet again, we face the complicated question of whether the fetus is a viable third party. Courts have ruled in different ways on this topic.

In 1981, in *Jefferson v. Griffin Spalding County Hospital Authority*, the Georgia Supreme Court upheld the decision to order a woman to undergo a cesarean delivery after she refused to consent on religious grounds, despite the physician's prediction that both the fetus and possibly the patient would die without surgery.²¹ The trial court in this case had ordered cesarean delivery based on its finding that "as a matter of law . . . this child is a viable human being and is entitled to the protection of the Juvenile Court Code of Georgia" (Ref. 21, p 459). The Georgia Supreme Court upheld the decision to order the woman to have a cesarean delivery based on the breech position of the fetus and likelihood of death; the court rejected her religious objections. During the court proceedings, the patient went into labor and subsequently had a normal, spontaneous vaginal delivery of a healthy baby.³

In 1964, in *Raleigh Fitkin-Paul Morgan Memorial Hospital v. Anderson*,²² the New Jersey Supreme Court ordered a mother to have a blood transfusion in the 32nd week of pregnancy, to save her life and that of her fetus. Similarly, in New York in 1985 in *In re Jamaica Hospital*,²³ the court ordered the transfusion of blood to a Jehovah's Witness at 18 weeks' gestation, finding that the state's interest in the not-yet-viable fetus outweighed the patient's interests. (Of note, the court appointed a special guardian for the fetus and upheld the guardian's order for a transfusion. We will discuss this ruling later.) More recently, in Florida in 1999 in *Pemberton v. Tallahassee Mem. Reg. Med. Ctr., Inc.*,²⁴ the U.S. District Court for the Northern District again acted in the interest of the fetus, holding that a pregnant mother's consti-

tutional rights did not outweigh Florida's interest in preserving the life of an unborn child in the case of a pregnant woman who refuses a cesarean section.

Other Considerations

California courts have held that child abuse and endangerment statutes do not apply to a fetus. In 1977, the California Court of Appeal (*Reyes v. Superior Court*) vacated the conviction of a mother who used heroin and gave birth to twin sons addicted to heroin.²⁵ The court found that the California child endangerment statute was not intended to apply to an unborn child. This line of thinking was upheld further in 1989 in *In re Troy D.*, in which the court found that if a child was born with drugs in its system, the child falls within the dependency statute.²⁶ However, the court noted that a fetus is not a child, and a dependency petition cannot be sustained on behalf of a fetus.

California law notably includes precedent for treating a fetus as a "human being." California's murder statute, California Penal Code § 187, was amended in 1970 to include the fetus in response to a highly publicized case in which a court held that a defendant who willfully killed a woman's unborn child by kicking her in the stomach was not guilty of murder. However, subsequent cases have interpreted the statute narrowly and have held that it does not apply to a woman who gives birth to a stillborn child after prenatal drug use (see, for example Ref. 27).

California law does, however, recognize a pregnant mother as a unique entity. California Penal Code § 1170.82 notes that the unlawful selling, furnishing, administering, or giving away of controlled substances to pregnant women, among others, shall be a "circumstance in aggravation of the crime" in imposing a term. The law is, however, less stringent than other states' in terms of identification, testing, and reporting. California Penal Code § 11165.13 states that a positive toxicology screen at the time of delivery of an infant is not a sufficient basis for reporting child abuse or neglect. However, any indication of maternal substance abuse should lead to assessment of the needs of the mother and child. The code further states that if other factors indicate risk to a child, then a report must be made to a welfare or probation department, not to a law enforcement agency.

Regarding third-party liability and the rights of a fetus, however, California law is as complex as that of

other states. Despite the legal precedent, the California Health and Safety Code (11705) notes that an individual exposed to an illegal controlled substance *in utero* may bring an action for damages caused by an individual's use of an illegal controlled substance against a person who sold, administered, or furnished an illegal controlled substance to the individual user of the illegal controlled substance. This seeming contradiction highlights the complexity of this issue.

An interesting point that has been raised sporadically over the years is the concept of legal counsel for the fetus. Indeed, the treatment team in our clinical case considered whether we should have pursued such an avenue. In Florida in 2004, this question was brought to the forefront when a severely mentally disabled woman became pregnant after being raped by the owner of the group home in which she lived.³ In this case, the wife of a Florida prosecutor sought to be appointed "guardian of the fetus" to prevent the mother, who had autistic disorder, mental deficiency, cerebral palsy, and a seizure disorder, from taking prescription drugs that could injure the fetus and to prevent the mother from having an abortion.³ The case was ultimately presented in front of the Florida District Court of Appeals (*In re J.D.S.*), and the court held that under the Florida guardianship statute, a guardian can be appointed only for a "person," and that fetuses are not persons under Florida law (Ref.28, p 536).

Another case in Alabama addressed the same question in 2003. In this instance (*Ex parte Anonymous*), the court affirmed the denial of a waiver of parental consent for an abortion.²⁹ During the legal proceedings, the trial court appointed guardians for both the pregnant minor and her fetus and allowed the fetus's guardian to cross-examine the minor during the court proceeding, which set a precedent that the fetus can have a guardian in such instances.

We have already noted the case of *In re Jamaica Hospital*²³ in 1985 in New York in which the court appointed a special guardian for the fetus and upheld the guardian's order for a transfusion.

Follow-up of the Case

After review of the legal aspects, we return to our case for follow-up. After losing a judicial hearing regarding her right to refuse psychotropic medication, she was prescribed haloperidol, with the dose titrated to 15 mg/d administered orally. She maintained that she was not pregnant, yet when asked for a substi-

tuted judgment—that is, when asked what she would want to do if she were pregnant—the patient said she would want to deliver the baby. Medical probate (a formal request made to a judge to allow a treatment team to administer nonpsychotropic medications and medical treatment against objection) was filed and granted, given that she was found incompetent; however, on a technicality, it was suspended one day before a normal spontaneous vaginal delivery. After the delivery, she began to acknowledge the baby as her own and expressed a desire to mother him. She remained delusional in her thinking about the pregnancy. She was released with intensive case management, and her child was placed in the custody of the child protective service system. Initially, she fought for parental rights, but, as of the writing of this article, she had abandoned that struggle and moved to another city.

Legal and Treatment Considerations for Clinicians

Given the case law that we have reviewed in this article, it is clear that the legal community continues to wrestle with how much to intervene in a pregnancy. Furthermore, both statutory and case laws vary state by state, and therefore clinicians must be aware of the rules and regulations of their individual jurisdictions. In our case, one might argue that the treatment team, in conjunction with appropriate legal counsel and consideration, could have made a decision based on the best-interest standard as outlined herein and highlighted by the case of D.R. in 1999.⁸ However, as we explored the issue, we quickly recognized that best interest could apply to the mother or the fetus, which complicates the question. In our case, the treatment team was fortunate to have been able to elicit what her preference would have been had she believed she was pregnant, although she was in a psychotic state when she was interviewed. The treatment team therefore based the remainder of her obstetric care on her statement about her wishes, in essence using substituted judgment. Whether the treatment team and legal counsel should have used best interest or substituted judgment is up for debate, as none of the legal precedent to date directly applies to this case.

Although we recognize that a solution to this quandary is outside the scope of this article, we propose that clinicians think carefully about how they

Psychotic Denial of Pregnancy

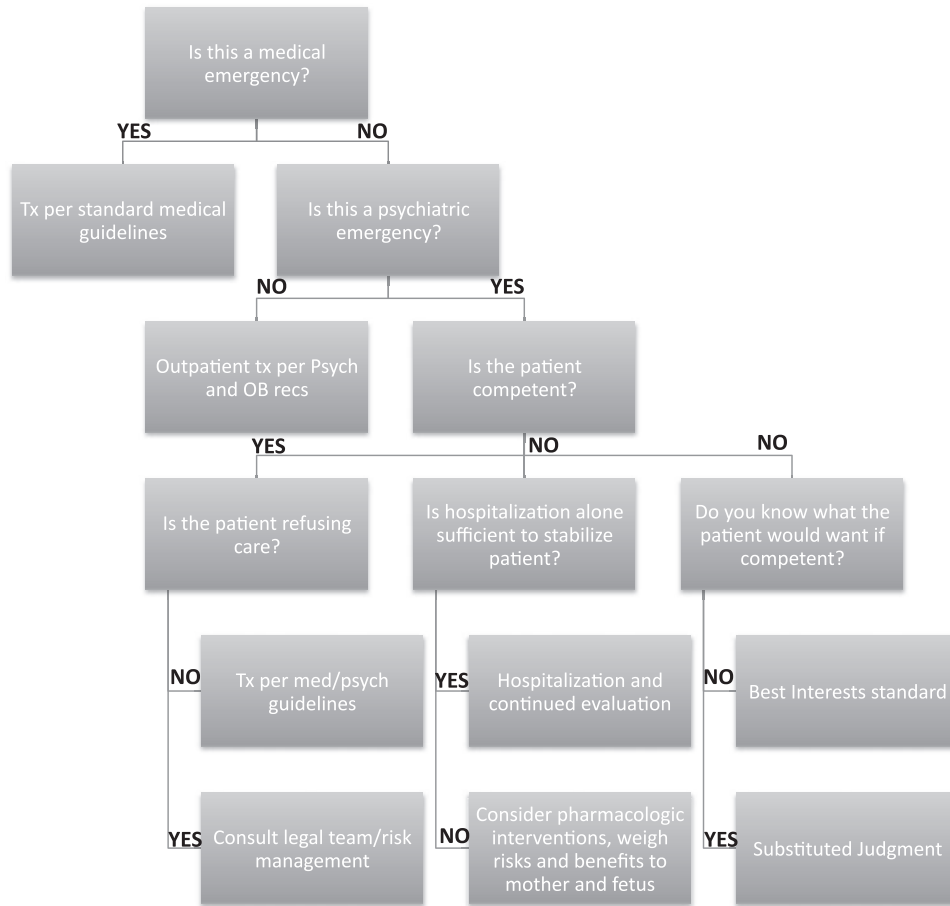


Figure 1. Proposed protocol for treatment of a pregnant woman with active psychosis.

manage the care of a mentally ill pregnant woman who refuses intervention.

In approaching this exceedingly complex situation, the authors believe that the following questions must be asked, at a minimum, before care of a pregnant woman with active psychosis is initiated:

Is this a medical emergency? (As a related question: How far along is the patient in her pregnancy?)

Is the patient competent or incompetent?

Is the patient's health in danger? Is the fetus' health in danger? Whose health is the true basis of treatment? Is this care legally permissible?

What would the patient want if competent? (Is substituted judgment a proper mechanism for determining treatment in this case?)

How does hospitalization affect the health of the patient and fetus? More specifically, is hospitalization alone a sufficient treatment, and are

medications truly necessary in this (or any other) case?

Would consultation with the legal team of the hospital be an appropriate way to address clinical decision-making regarding the patient? At what point does this become a purely legal question and lie outside the scope of the right of doctors to intervene?

We propose Figure 1 as a way to approach these important questions.

We conclude that it is of primary importance that the clinician follow accepted clinical and legal precedent and remain aware of these considerations. Furthermore, clinicians must attempt to serve their patients without making a determination of whether the fetus is in fact a person and the primary patient, thus avoiding the abortion debate. In this article the authors have attempted to offer other means of clinical and legal evaluation to assist clinicians in this endeavor.

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26. *In re Troy D.*, 215 Cal. App.3d 889 (Cal. Ct. App. 1989)
27. *People v. Jones*, No. 93-5, Transcript of Record (Cal. J. Ct. Siskiyou Cty July 28, 1993)
28. *In re J.D.S.*, 864 So.2d 534, 536 (Fla. Dist. Ct. App. 2004)
29. *Ex parte Anonymous*, 889 So.2d. 525 (Ala. 2003)