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Psychiatrist's opinion as a premise for legal termination of pregnancy

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Summary

The article presents the provisions currently in force in Polish legislation regarding legal termination of pregnancy. In particular, it refers to the premise of a psychiatrist's decision that the health of a pregnant woman is at risk. Under Polish law, termination of pregnancy is generally prohibited and penalized. However, there are two exceptions to this prohibition. Such a procedure is permitted if: the pregnancy poses a threat to the life or health of the pregnant woman, or if there is a reasonable suspicion that the pregnancy was the result of a prohibited act. The text presents an overview of the relevant regulations and tips on their

interpretation and application in everyday medical practice. This issue is particularly important for psychiatrists consulting maternity wards. In addition, the most important mental disorders related to pregnancy and childbirth are described. The clinical features and prevalence of perinatal mood disorders and psychoses are presented. The issue of suicide among pregnant and postpartum patients was also discussed. A sample certificate template was proposed, and guidelines were discussed as to what information and conclusions should be included in the opinion of a psychiatrist.

Key words: pregnancy, women's mental health, psychiatrist's opinion

Introduction

Under the Polish law, termination of pregnancy is generally prohibited and criminally sanctioned, even if the pregnant woman gives her consent to such a procedure [1]. Whereas, the criminal liability is limited to the person who actually performs an abortion, it is not incurred by the pregnant woman who induced them to carry it out. However, there are two exceptions to this ban as set out in Article 4a(1) of the Act of 7 January 1993 on Family Planning, Protection of the Human Foetus and the Conditions Permitting Pregnancy Termination [2]. Namely, such a procedure is permitted if the pregnancy poses a threat to the life or health of the pregnant woman (Item

1 – so-called therapeutic premise), or if there are reasons to suspect that a pregnancy is a result of an unlawful act (Item 3). As regards the first premise, it is necessary that the occurrence of such a risk is confirmed by a doctor, as a rule, other than the one who performs the abortion procedure. Nevertheless, the statutory regulations do not precisely define what specialisation a doctor, authorised to give such an opinion, should have. Certain indications can, however, be found in the implementing act, i.e. the Regulation of the Minister of Health and Social Welfare of 22 January 1997 on the professional qualifications of doctors that authorise them to terminate pregnancy and confirm that it is a threat to the life or health of the woman, or that it indicates a high probability of irreversible foetal defect or an incurable illness which threatens the foetus's life [3]. Pursuant to § 2(2) of the Regulation, the occurrence of the said circumstances should be established by a doctor who is a specialist in the field of medicine appropriate to the type of illness the pregnant woman suffers from. Thus, for example, if the risk resulted from a heart disease, a cardiologist would be the competent specialist. If, on the other hand, the patient was affected by cachexia or many various illnesses, such an assessment could be made by a specialist in internal or family medicine [4]. The question arises, however, whether a psychiatrist is also competent in this respect. In order to answer this question, first it must be established whether health risks for a pregnant woman relate only to her somatic or also mental health. Also, if a psychiatrist had such an authority, what criteria should guide their assessment, and when they could issue an opinion stating that there is a risk to the mental health of the pregnant woman which gives grounds for termination of pregnancy.

There is currently an ongoing discussion on changing the above-mentioned regulations towards liberalizing the conditions for the admissibility of termination of pregnancy. A draft bill on safe termination of pregnancy has been submitted to the Sejm of the Republic of Poland (sejm paper no. 177), which provides that such a procedure will be allowed until the end of the twelfth week of pregnancy. Later, however, the pregnancy may be terminated, among others, if it constitutes a threat to the life or physical or mental health of the pregnant woman. Therefore, the therapeutic premise is maintained, only specifying that the threat may also concern mental health. The planned changes to the Penal Code regarding the crime of illegal termination of pregnancy are correlated with this project. Pursuant to the amendment act (Act amending the Penal Code, Parliamentary Paper No. 176), termination of pregnancy within the twelfth week of its duration is to be decriminalized. Moreover, the provisions specifying aiding in the termination of pregnancy are repealed (Article 152 § 2 of the Penal Code) and the sanctions for performing such a procedure with the consent of the pregnant woman are relaxed. Until now, this offense was punishable by imprisonment for up to 3 years, but according to the bill, it would be punishable by a fine or restriction of liberty. The therapeutic premise in its current form is also retained in the draft amendment to the act submitted by the Third Way group. Therefore, regardless of the further legislative fate of these provisions, it can be assumed that the therapeutic condition will continue to apply, the fulfillment of which will require an assessment by a doctor. Taking into account that the presented project clearly mentions the threat to mental health as a justification for abortion, this doctor will most likely be a psychia-

trist. Therefore, both under the current legal status and the proposed amendment, the role of a specialist in this field will be invaluable. It is therefore desirable to present the principles of opinion-giving proceedings in this area, carried out by a psychiatrist.

These issues will be approached in the following discussion, with the legal aspects being discussed first and supplemented by psychiatric considerations.

1. Regulatory models of permissibility of pregnancy termination

The scope of protection of the conceived life depends on the model defining the conditions of permissibility of pregnancy termination adopted in a given country. The medico-legal literature points to two models, i.e. abortion on request of the pregnant woman and medically indicated abortion.

The former is based on the assumption that the foetus itself is not the object of legal protection but is part of the pregnant woman's body. She can therefore freely dispose of her body, and thus decide to terminate pregnancy. The protection of the unborn child is therefore dependent on the pregnant woman's will. Therefore, a woman's request for performing an abortion is sufficient to regard it as a lawful act. Moreover, it does not matter what motives she is driven by when making this decision. However, to ensure that the decision is not rash, these systems introduce appropriate procedures prior to pregnancy termination. In particular, they are related to the medical aspect, e.g. it is established whether termination of pregnancy will not be a threat to the life or health of the pregnant woman. It is therefore examined whether there are any contraindications. If so, it will not be possible to perform such a procedure, and thus, in fact, the life of the unborn child will be protected. However, it will be an indirect impact since the primary protection will be focused on the health of the pregnant woman. Before making the final declaration, the pregnant woman is informed on the consequences of her decision, including the health effects, as well as on support that she may be provided with by the state if she decides to give birth after all. Having obtained this information, the woman can take her final decision that doctors have to abide by. Such solutions have been adopted, among others: in the Kingdom of Spain, where this issue is regulated by the Act of March 3, 2010 on sexual and reproductive health and voluntary termination of pregnancy – (*Ley Orgánica 2/2010, de 3 de marzo, de salud sexual y reproductiva y de la interrupción voluntaria del embarazo*) [5]. Pursuant to its Article 13 bis section 1 woman may voluntarily terminate her pregnancy from the age of 16, without the need to obtain the consent of her legal representatives. This procedure is carried out until the 14th week of pregnancy. In the case of a more advanced pregnancy, there must be additional conditions justifying abortion, in particular "a serious threat to the life or health of the pregnant woman" (Article 15(a) of the Act). In each case, however, a woman who intends to undergo this procedure receives information from medical staff about various ways of terminating pregnancy (surgical and pharmacological), conditions of the procedure, facilities to which she may be directed, etc.

Whereas, the concept of medically indicated abortion is based on the assumption that the unborn child constitutes a separate value to be protected. The will expressed by the pregnant woman is a necessary (*sine qua non)* condition for the legality of

abortion, however, it is not sufficient. There must be additional circumstances that justify violation of the unborn child's right to life, i.e. the so-called indications. These circumstances should be described in legislation, and their actual occurrence is subject to objective verification by a state authority [6]. The scope of protection, and thus the catalogue of indications, depends on the axiological system adopted in a given community. Therefore, the protection will in particular derive from determination of the nature and value of the unborn child's life. In systems that regard the life of the foetus affirmatively, the so-called direct subject-oriented protection is applied. It is considered that the unborn child has the same rights and is protected in the same way as a human being already born. Pregnancy termination, which results in depriving an unborn child of their life, is therefore treated as homicide. Abortion may only be permissible in a state of higher necessity, i.e. if a pregnant woman faces an immediate risk of losing her life. If, however, there is a threat to the woman's health only, it is not a sufficient reason for the abortion procedure to be considered legal. Protection can also have a direct but object-oriented nature. In this case, the foetus is treated as the so-called non-personal subject of law which is given protection just like other significant values. In this variant, it is forbidden to deprive the foetus of life or to cause its damage, either by the pregnant woman herself or by any third parties, such as doctors [7]. However, there may be reasons that justify such behaviour, i.e. the aforementioned indications. Their scope will depend on whether a community is more liberal or more conservative in its views of the woman's right to decide about her pregnancy. In liberal systems, the grounds for permissibility of abortion are broadly defined and may have different aspects, e.g. a social dimension (such as a difficult material situation of the pregnant woman) or a moral dimension (such as extramarital pregnancy). Whereas, in more conservative systems, these indications are more strongly restricted, e.g. only to cases of threat to the life or health of the pregnant woman. At the same time, the severity of this threat is assessed in a relative way, according to the adopted axiological system. Depending on the importance of the value, which is the life of the unborn child, any threat (broad definition of indications) or only a serious direct one (narrow definition of indications) may be regarded as sufficient. This system dominates in European countries. As an example, we can cite the Czech Act of October 20, 1986 on artificial termination of pregnancy – *Zakon o umělém přerušení těhotenství* [8]. According to section 7, abortion may be performed up to the twelfth week of pregnancy without the need to meet additional conditions. However, in the case of a more advanced pregnancy, artificial termination is permissible "for medical reasons" if the life, health of the pregnant woman or normal development of the fetus are at risk, or if the development of the fetus is genetically defective.

In the context of the presented models and considering the Polish regulation, it may therefore be assumed that the Polish legislator opted for the model of indications and their defined scope is relatively narrow. However, it did not state that the unborn child is to be provided with protection each born human being is entitled to. This is because the legislator allows the possibility of terminating a pregnancy not only when there is an immediate threat to the life of the pregnant woman. Such a procedure is also permitted when there is a threat to her health. However, this premise is vague.

Firstly, it is not clear whether it is only a threat to health in somatic terms or also in mental terms. Secondly, it is not explicitly defined how severe this threat must be. These issues will be discussed in the next section.

2. Threat to the health of a pregnant woman as a premise for permissibility of pregnancy termination

As previously mentioned, the legislation permits termination of pregnancy if there is a threat to the health of a pregnant woman. However, the law does not define the concept of health, nor does it limit this prerequisite to a threat related to somatic health only.

The dictionary defines health as "the state of a living organism whose all functions run properly: full fitness and physical and mental well-being" [9]. Whereas, in the medical literature, the concept of health means "a state of full physical, mental and social well-being; in a narrower sense, the absence of disease or disability; from a physiological point of view, health is the full ability of a body to maintain balance between itself and the external environment, to respond properly to changes in the environment and adapt to these changes" [10].

Without any further analysis of the concept of health, it can be assumed that modern health sciences treat a human being holistically, looking at the causes of disease through many factors. Occurrence of an illness depends on genetic predispositions, social conditions of the environment and lifestyle factors [11]. The World Health Organization (WHO) holds a similar opinion on this issue. In the preamble to its Constitution, the organisation declares that "health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity" [12]. These views imply that health includes both a physical (somatic) and a mental component. However, it is very difficult to give a clear definition of the concept of mental health. One way to make a division between health and mental disorders is to use the criterion of deviation from the norm. However, it can be understood in statistical, cultural and theoretical terms, and none of these is perfect [13]. Nevertheless, the concept seems to be referred to in court rulings. To give an example, the judgment of the Supreme Administrative Court of 19 February 2008 [14] may be mentioned, in which the court explained that

> *the term 'mental health', regarded as part of the general concept of 'health', refers to mental and emotional well-being. Psychiatric health is defined as the ability of any person to develop and function mentally in a normal way. That is, a mentally healthy person is one in whom the functioning of the brain, nervous system, sensory organ system and the endocrine system is not disturbed, so that they can manage the demands of daily life, and their behaviour is similar to that of most people we call normal. At the same time, it is emphasized that the absence of a diagnosed mental illness does not necessarily imply mental health.*

This view is shared in subsequent judgments [15]. On statutory grounds, however, this concept has not been defined. In particular, it is not included in the Act of 19 August 1994 on the Protection of Mental Health [16]. Its preamble merely raises the point that mental health is a fundamental personal right of a human being. Therefore, it constitutes an important value that should be protected both legally and in fact. Its significance is also highlighted in judicial decisions [17]. Violation of this right is therefore permissible only if it is justified by the need to protect other vital interests. This thesis is important in the context of the discussed topic, i.e. the threat to the health of a pregnant woman as a premise for the permissibility of termination of pregnancy. This is because, as already mentioned, Article 4 (1) (1) of the Act on Family Planning, Protection of the Human Foetus and the Conditions Permitting Pregnancy Termination allows abortion in the case of such a threat. However, the legislator did not limit this option to the occurrence of a risk in terms of somatic health only. Whereas, the presented considerations demonstrate that the concept of health also includes mental health, which is considered to be a significant social value. To conclude, it can therefore be assumed that abortion will also be permitted when there is a threat to mental health alone. The Ministry of Health [18], the Patients Ombudsman [19] and the Ombudsman [20] share this view.

In such a case, a psychiatrist will be competent to assess the occurrence of such a premise and issue an appropriate opinion (certificate). However, the question arises as to how serious the threat that occurs must be to regard termination of pregnancy as justified.

As stated in the previous section, the Polish legislator adopted the so-called medically indicated model. It derives from the assumption of a collision of interests. The life of the unborn child, which is subject to legal protection, is contrasted with another value, i.e. the health of the pregnant woman. Depriving an unborn child of their life will be permissible only if it is socially beneficial, i.e. if sacrificing the life of the foetus will be necessary to protect the woman's health threatened so severely that the annihilation of another value, which is the life of the unborn child, will be justified in social terms. Thus, the question arises as to how the value of foetal life is assessed in the context of the Polish law and medical-legal doctrine. This issue was considered by the Constitutional Tribunal which ruled on the compliance of Article 4a(1)(4) of the Act on Family Planning, Protection of the Human Foetus and Conditions Permitting Pregnancy Termination with the Constitution of the Republic of Poland, among others. The provisions of the said Act allow pregnancy termination for social reasons [21]. In the presented reasons for this ruling, the Tribunal emphasises that the life of the unborn child is protected at the constitutional level. It therefore represents a significant social value. Such protection also derives from statutory acts. The legislator explicitly presents the opinion on the subject in Article 1 of the Act on Family Planning, Protection of the Human Foetus and the Conditions Permitting Pregnancy Termination, decreeing that the right to life is subject to protection, also in the prenatal stage. The significance of this value is also confirmed by the protection of the life and health of the unborn child provided for under the Criminal Code. Indeed, as stated, it is an offence to terminate a pregnancy even with the consent of the pregnant woman

(Article 152 § 1 of the Criminal Code). Moreover, the act of causing serious bodily injury to an unborn child has been penalised [22]. Thus, despite the fact that the Polish legislator does not treat an unborn child equally to a human being that has already been born, it follows from all the regulations that in our axiological system, the life and health of the unborn child are perceived as precious values. However, protection of these values is not absolute. As the Tribunal justifies:

> *the assumption that human life, including life in the prenatal stage, is a constitutional value, does not yet mean that in certain exceptional situations protection of this value may not be limited or even excluded due to the necessity of protection or implementation of other constitutional values, rights or freedoms.*

The legislator decided that the health of a pregnant woman could be such a value. However, it did not specify what threat it referred to. Still, it may be assumed that this threat occurs if pregnancy was the cause of a particular disease (e.g. pregnancy poisoning), or when the pregnant woman had already suffered from an illness before, and her condition was aggravated by pregnancy (e.g. circulatory disorders). In this context, it may be considered that the risks in this area may also involve mental health, both when the woman has already suffered from disorders in this sphere, which were aggravated by pregnancy, and when pregnancy led to such disorders. From this perspective, it appears that the fact the foetus is affected by lethal anomalies could also be the grounds for identifying a threat in the mental sphere. The awareness of such defects that a pregnant woman has and, consequently, of delivering a baby affected by such anomalies, particularly if it is highly likely that the baby will die shortly after birth, can result in mental disorders. It is therefore conceivable that a psychiatrist would conclude that for such reasons, there is a risk to the mental health of the pregnant woman.

The discussed regulations do not limit the risk to situations of direct threat to life or health only. If the legislator wants such a limitation to be introduced, it is explicitly expressed in a provision (e.g. Article 4a of the said Act states that, as a rule, such circumstances are ascertained by a doctor other than the one who terminates pregnancy, unless the pregnancy is a "direct" threat to the woman's life). On the contrary, it can therefore be assumed that, in the analysed context, the threat does not have to be direct. From the legal perspective, the concept of immediacy is understood in different ways [23]. Generally speaking it denotes the proximity of a given event in time or its inevitability. To identify a threat based on this premise, it is neither necessary for the threat to the pregnant woman's mental health to materialise in the short term, nor for that materialisation to be inevitable, even in the long perspective. The legislator does not require that the threat be serious either. In this respect, however, what must be taken into account are the theoretical assumptions of the model of permissibility of pregnancy termination under discussion. As explained, such a procedure is permissible if it is justified by the need to protect the health of the pregnant woman, and the risk cannot be avoided otherwise. Moreover, it is sufficiently serious to justify sacrificing an important value such as the life and the health of the unborn child. The doctor carrying out the assessment must therefore decide how real and serious the threat to the mental

health of the pregnant woman is, and therefore establish whether the degree of that threat would justify depriving the unborn child of their life. However, the legislation does not provide any guidance in this regard, leaving the assessment to a psychiatrist. Undoubtedly, however, the resulting state of emergency must be characterised by a higher probability of negative consequences than the normal risks associated with the course of pregnancy and childbirth. In the literature, one may find the opinion that, even if the state of emergency is not fully defined, it should be assumed to be serious, given the theoretical and legal considerations discussed [24]. Furthermore, adopting the assumptions of the concept of indications, it should be considered that pregnancy termination will be permitted if it is an adequate measure to overcome the diagnosed threat. In other words, the prognosis for such an intervention should be positive in terms of eliminating the threat to the mental health faced by the pregnant woman. Only then can the act of depriving the unborn child of their life be justified. A psychiatrist should also consider this aspect before issuing a relevant certificate.

However, it must be emphasised that a psychiatrist acts only as an expert consultant. In their opinion, they therefore state whether or not they diagnose a particular disease entity that may endanger the mental health of the pregnant woman, and whether or not the occurrence of this disease induces a risk that is significant enough to justify pregnancy termination. However, it must be clearly stated that a psychiatrist who gives such an opinion does not decide on pregnancy termination. This is because the certificate issued by them is only a certain element in the abortion procedure. Ultimately, the decision rests with the pregnant woman who, based on the information she obtains about her mental health and possible risks in this area, among others, can decide whether or not she wishes to give birth to the child. Additionally, a potential abortion will depend on gynaecological factors, so in this respect, the decision will rest with the doctor performing the procedure.

To complete the picture, it is worth adding that a decision issued by a psychiatrist may be questioned by a pregnant woman. The possibility of filing an objection to the judgment and the applicable procedures are described in Article 31 and 32 of the Act of November 6, 2008 on patient rights and the Patients Ombudsman [25]. According to them, the patient or his legal representative may raise such an objection if the decision affects his rights or obligations. In the case of a decision issued by a psychiatrist in a case concerning termination of pregnancy, the substantive decision will naturally be important from the perspective of further abortion procedures to which the pregnant woman is to undergo. This position will therefore be relevant to her exercise of her statutory entitlement. The objection must be submitted to the Medical Commission operating at the Patients Ombudsman within 30 days of issuing the decision. It requires justification, in particular an indication of the legal provision that gives rise to the rights affected by the ruling. The Medical Commission, which resolves the objection, consists of three doctors appointed by the Patients Ombudsman, two of them from the same specialty as the doctor who issued the decision. In the situation in question, these will be two psychiatrists. The committee makes its decision on the basis of medical documentation and, if necessary, after examining the patient. It should complete its activities within 30 days from the date of filing the objection. The Commission's decisions

are final and cannot be appealed against. Without a doubt, this is a solution to protect the rights of a pregnant woman in the event of a ruling that is inconsistent with her expectations – stating that there are no indications for terminating the pregnancy. In this way, she can obtain a ruling allowing her to have an abortion. However, it seems that the waiting period for the Commission's decision may be too long in terms of medical conditions for terminating pregnancy. It is therefore desirable to introduce appropriate regulations allowing for more efficient consideration of such cases. The solutions adopted in the already mentioned Czech Act on artificial termination of pregnancy may serve as an example. Pursuant to section eight of this Act, if the doctor does not find conditions for artificial termination of pregnancy, the woman may, within 3 days, request the district expert in the field of gynaecology and obstetrics to reconsider her application. This expert considers the application within 2 days of its delivery. The decision is made based on consultation with two other doctors in the field of obstetrics and gynaecology, and may also refer to a doctor of another specialty, appropriate to the health condition of the pregnant woman. If he finds that there are grounds for artificial termination of pregnancy, it notifies the woman and at the same time indicates the medical facility where the procedure can be performed. However, if he does not see the need to artificially terminate the pregnancy and the woman still demands such a procedure, the district expert submits her written application for consideration to the district expert in the field of gynaecology and obstetrics. The Act states that such transfer should take place immediately, i.e. as soon as possible. The district expert also uses the opinion of two other doctors in the field of gynaecology and obstetrics and may consult a doctor of another specialty. The application will be considered within 3 days of its delivery. If it finds grounds for artificial termination of pregnancy, it informs the woman and indicates the facility where the procedure will be performed. However, if no such indications are found, he informs the woman about it and thus ends the procedure. This decision is final and is not subject to further appeal. It follows from this regulation that the review of a medical certificate takes place in two stages, in a relatively short period of time. Therefore, it seems that this solution is beneficial from the point of view of protecting the rights of pregnant women.

Considering the fact that the Polish legislator did not in any way specify the conditions related to risks to the pregnant woman's mental health that would justify pregnancy termination, *in concreto* assessment by a psychiatrist is necessary. However, based on the current medical knowledge and experience in psychiatry, it is possible to identify certain conditions the occurrence of which may give rise to issuing of the opinion in question [26]. These circumstances will be discussed in more detail in the next medical section of this article.

3. Pregnancy-related mental disorders

Contrary to commonly expressed views, pregnancy and the postpartum period do not protect a woman's mental health. On the contrary, it is believed that no other period in a woman's life carries such a high risk of redeveloping affective disorders or psychosis as the first four weeks after childbirth. Also, a particularly increased vulner-

ability is observed during pregnancy (highest risk in the second and third trimester) and the first six months following delivery [27]. The only perinatal mood disorder that does not require therapeutic intervention and does not pose a risk to women is postpartum blues (baby blues; maternity blues). It is a common phenomenon, affecting from 40% to 85% of women [28]. It develops as a consequence of a sudden decrease in hormone levels and the stress accompanying childbirth. Symptoms appear within ten days after delivery, reaching a peak in severity between days 3 and 5 and a tendency to self-limit over time. Whereas, postpartum depression affects about 15% of women, however, it is known that in about 7–13% of patients symptoms actually appear already during pregnancy [27]. Pregnancy-related psychosis, on the other hand, affects about 0.2% of women and should most often be considered as severe affective episodes with concurrent psychotic symptoms [29, 30]. A particularly high risk of psychosis, approximately 25–50% after each birth, occurs in patients who have experienced postpartum psychosis in a previous pregnancy, or those who have suffered from bipolar affective disorder earlier. A family history of these conditions is an additional substantial risk factor. Whereas, a primary history of postnatal affective psychosis implies a significantly higher risk of developing bipolar affective disorder than in the general population (35–65%) [31]. Peripartum psychosis corresponding to the clinical picture of schizophrenia is observed much less frequently. In both cases, the severity of symptoms can be very high and usually requires urgent psychiatric intervention and hospitalisation. It should not be forgotten that in the peripartum period, pre-existing illnesses or psychiatric disorders may also reoccur or exacerbate, especially when the patient abruptly stops pharmacological therapy due to pregnancy [32].

Also, it must be emphasised that among women who seek psychiatric assistance in the peripartum period, 5–14% of patients experience suicidal thoughts [33]. Significant risk factors for suicide in this population include diagnosed unipolar or bipolar affective disorder, a history of suicide attempts, sudden psychiatric medication withdrawal during pregnancy, sleep disorders in the postpartum period, aggression from the partner, stillbirth, young age of the mother, unwanted and unplanned pregnancy [34, 35]. Suicide is one of the most common causes of maternal mortality in women [33], and suicidal risk remains high for up to a year following delivery. It is estimated that about 4.5% of women with peripartum psychotic depression commit infanticide. Typically, such acts are motivated by ego-syntonic delusions, which further increases the likelihood that they will actually be performed [36].

4. Psychiatrist's opinion

Considering the current medical knowledge of mental disorders in the peripartum period, there is no doubt that mental illness, especially active psychosis, in almost every case will pose a real and serious threat not only to the health but often also to the life of the pregnant woman. However, as mentioned in the first part of the article, the lack of diagnosis of mental illness does not mean the same thing as mental health. It should be noted that also diagnoses categorised as mental disorders, which are com-

monly assigned less importance, may prove to be a premise that indicates a risk to the patient's health. Due to the vagueness of the definition of a threat to a woman's health, which has been repeatedly emphasised here, each case should be treated individually. This is because it is not only the diagnosis that matters but also the previous course of treatment (therapeutic effects, the patient's cooperation in treatment, the dynamics and persistence of symptoms). It is also crucial to take into account factors that exacerbate or contribute to the development of mental disorders, risk factors for suicide, but also protective factors. Paradoxically, the prognosis for a patient with diagnosed, for example, depressive disorder, but with many-year remissions, a mild course of episodes, a supportive family and partner, in a stable social situation, may be better than that for a woman with, a diagnosis such as personality disorder or adjustment disorder, experiencing multiple emotional deprivation episodes, without any family or partner support, with a history of self-harm, suicide attempts, in a difficult social situation, with an unplanned pregnancy.

It should be assumed that in many cases a psychiatrist will issue a medical certificate for a pregnant patient after a single consultation appointment in a non-psychiatric hospital or an outpatient clinic. This is a particularly difficult task as it involves issues of great importance, and the action taken by the doctor may be verified and assessed both by the patient, her relatives, doctors of other specialties, and state authorities. It is certainly easier to give this kind of an opinion for a psychiatrist who has treated the woman even before the pregnancy and knows her personal situation and past medical history well. The authors of this article believe that, in every patient, and especially in the case of a single assessment, the psychiatrist should not be limited to just establishing a diagnosis and issuing a brief opinion about possible risks to the woman's health. It would be reasonable to describe anamnesis information more thoroughly, taking into account the patient's family situation and socioeconomic history [37, 38]. It is also necessary to refer to suicide risk in the context of not only current, but also past symptoms or possible suicide attempts. As mentioned in the first part of the article, the risk to a woman's health was not specified as immediate, so the consultant-psychiatrist should somehow anticipate the further development of psychopathological symptoms, along with their potential negative consequences for various spheres of the woman's life, as well as treatment options and prognosis. The psychiatrist's task is all the more difficult and burdened with responsibility since the conclusions of their opinion must be based on the currently observed symptoms and on the anticipated scenarios for the further course of mental disorders. In this context, it is necessary to analyse the expected emotional response of the woman when she becomes aware of her child's illness and inevitable death, but also her reaction to the potential threat to her own health or life. This can result in even extremely severe psychopathological symptoms, including anxiety, and disorganising everyday functioning. In this case, personality structure, mechanisms of emotion regulation and coping with stress are of considerable importance, even if the woman does not have signs of mental illness [38]. Thus, it seems optimal that a medical certificate should include a kind of psychiatric opinion reasoning which would provide grounds for the presented conclusions. The authors of this article offer readers a certificate template, which, in the light of the regulations

in force, can be helpful for specialists in psychiatry when formulating an opinion following consultation on pregnancy termination.

MEDICAL CERTIFICATE
Full name:
Personal Identification Number /PESEL/:
Address:
Diagnosis:

Medical opinion:

This is to certify that the diagnosed mental disorder/mental illness occurring during pregnancy constitutes a threat to the life/health of the pregnant woman, which fulfils the premise of permissibility of pregnancy termination referred to in Article 4a(1)(1) of the Act of 7 January 1993 on Family Planning, Protection of the Human Foetus and the Conditions Permitting Pregnancy Termination (Journal of Laws of 2022, item 1575).

(the opinion should indicate whether the diagnosed mental disorder/ mental illness could cause a real threat to the life or health of the pregnant woman, now or at further stages of the pregnancy)

Grounds:

(In this section, it should be indicated, based on the obtained information, medical history, medical records, etc., how the diagnosed mental disorder/mental illness may affect the health of the pregnant woman; in particular whether the symptoms resulting in a threat to the patient's health/life may aggravate, now or at further stages of the pregnancy. It should also be specified which factors provide grounds for such an opinion, e.g. previous course of illness, lack of support from the patient's close persons, or difficult family situation, which may negatively affect the mental well-being of the pregnant woman).

Date Stamp and signature of the doctor

References

1. Article 152 § 1 of the Penal Code.
2. Dz. U. (Journal of Laws) of 2022, item 1575.
3. Dz. U. (Journal of Laws) No. 9, item 49 (2004; 103: 698–709).
4. Zielińska E. *Wzajemne relacje w zespołowym działaniu medycznym w aspekcie odpowiedzialności karnej i zawodowej*. Prawo i Medycyna 2001; 9: 38–47.
5. https://www.boe.es/buscar/act.php?id=BOE-A-2010-3514 (retrieved: 18.02.2024).
6. Zielińska E. *Oceny prawnokarne przerywania ciąży. Studium porównawcze*. Warsaw: University of Warsaw Press; 1986. S. 194–204.
7. Konarska-Wrzosek V. *Ochrona dziecka w polskim prawie karnym*. Torun: TNOiK „Dom Organizatora"; 1999. P. 10–23.

8. https://www.zakonyprolidi.cz/cs/1986-66 (retrieved: 18.02.2024).
9. Dubisz S, editor. *Wielki słownik języka polskiego PWN*, vol. 5. Warsaw: Polish Scientific Publishers PWN; 2018. P. 826.
10. Rożniatowski T, editor. *Mała encyklopedia medycyny*. Warsaw: Polish Scientific Publishers; 1979. P. 1426–1427.
11. Jakubowska-Winecka A, Włodarczyk D, editors. *Psychologia w praktyce medycznej*. Warsaw: PZWL; 2007. S. 36.
12. The Constitution of the World Health Organization, Agreement concluded by the Governments represented at the International Health Conference and Protocol on the International Office of Public Hygiene, signed in New York on 22 July 1946 r. (Dz. U. (Journal of Laws) of 1948, No. 61, item 477 as amended).
13. Kubiak R. *Odpowiedzialność karna za wykonywanie zabiegów kosmetycznych. Zagadnienia teorii praktyki*. Krakow: Medycyna Praktyczna; 2012. S. 140–148.
14. File reference: I OSK 117/07, LEX No. 454083.
15. Judgment of the Supreme Administrative Court in Warsaw of 17 November 2008, file reference: I OSK 1467/07, LEX No. 525958 and judgment of the Voivodship Administrative Court in Poznan of 18 March 2009, file reference: II SA/Po 842/08, LEX No. 543882.
16. Dz. U. (Journal of Laws) of 2022, item 2123.
17. Resolution of the Supreme Court of 12 February 1997, file reference: II CKU 72/96, OSNC 1997/6 – 7/84; judgment of the Supreme Court of 7 November 2000, file reference: I CKN 1149/98, LEX No. 50831.
18. Letter dated July 20, 2023, file reference: ZPR.660.24.2023.AB. https://bip.brpo.gov.pl/sites/default/files/202307/Odpowiedz_MZ_aborcja_zdrowie_psychiczne_20.07.2023.pdf (retrieved: 7.08.2023).
19. Letter dated July 27, 2023, file reference: RzPP-DPR-WPZ.420.30.2023.PP. https://bip.brpo.gov.pl/sites/default/files/2023-07/Odpowiedz_RPP_aborcja_zdrowie_ psychiczne_ 27.07.2023.pdf (retrieved: 7.08.2023).
20. https://bip.brpo.gov.pl/pl/content/rpo-aborcja-zdrowie-psychiczne-matki-mz-rpp-odpowiedzi (references: 7.08.2023).
21. Judgment of the Constitutional Tribunal of 28 May 1997, file reference number: K 26/96, OTK 1997/2/19.
22. Article 157a of the Penal Code.
23. Lachowski J. *Stan wyższej konieczności w polskim prawie karnym*. Warsaw: C.H. Beck; 2005. P. 80–84.
24. Zoll A. In: Zoll A, editor. *Kodeks karny. Część szczególna. Komentarz*, vol. 2. Warsaw: Wolters Kluwer; 2013. S. 333.
25. Dz. U. (Journal of Laws) of 2023, item 1545 as amended.
26. By way of the ordinance of 12 June 2023 on the establishment of the Team for the development of guidelines for medical entities in the field of procedures related to the termination of pregnancy (Dz. Urz. Min. Zdrow. (Journal of Laws of the Ministry of Health), item 42).
27. Bennett HA, Einarson A, Taddio A, Koren G, Einarson TR. *Prevalence of depression during pregnancy: Systematic review*. Obstet. Gynecol. 2004; 103(4): 698–709.
28. Luciano M, Sampogna G, Del Vecchio V, Giallonardo V, Perris F, Carfagno M et al. *The transition from maternity blues to full-blown perinatal depression: Results from a longitudinal study*. Front. Psychiatry 2021; 12: 703180. Doi: 10.3389/fpsyt.2021.703180

29. Munk-Olsen T, Laursen TM, Mendelson T, Pedersen CB, Mors O, Mortensen PB. *Risks and predictors of readmission for a mental disorder during the postpartum period*. Arch. Gen. Psychiatry 2009; 66(2): 189–195.
30. Bergink V, Berg den MP, Koorengevel KM, Kupka R, Kushner SA. *First-onset psychosis occurring in the postpartum period: A prospective cohort study*. J. Clin. Psychiatry 2011; 72(11): 1531–1537.
31. Bergink V, Kushner SA. *Postpartum psychosis*. In: Galbally M, Snellen M, Lewis A, editors. *Psychopharmacology and pregnancy*. New York: Springer; 2014. P. 139–149.
32. Cohen LS, Altshuler LL, Harlow BL, Nonacs R, Newport DJ, Viguera AC et al. *Relapse of major depression during pregnancy in women who maintain or discontinue antidepressant treatment*. JAMA 2006; 295(5): 499–507. Erratum in: JAMA. 2006; 296(2): 170.
33. Rodriguez-Cabezas L, Clark C. *Psychiatric emergencies in pregnancy and postpartum*. Clin. Obstet. Gynecol. 2018; 61(3): 615–627.
34. Lindahl V, Pearson JL, Colpe L. *Prevalence of suicidality during pregnancy and the postpartum*. Arch. Womens Ment. Health 2005; 8(2): 77–87.
35. Orsolini L, Valchera A, Vecchiotti R, Tomasetti C, Iasevoli F, Fornaro M et al. *Suicide during perinatal period: Epidemiology, risk factors, and clinical correlates*. Front. Psychiatry 2016; 7: 138. Doi: 10.3389/fpsyt.2016.00138.
36. Brockington I. *Suicide and filicide in postpartum psychosis*. Arch. Womens Ment. Health 2017; 20(1): 63–69.
37. Pinna G, Almeida FB, Davis JM. *Allopregnanolone in postpartum depression*. Front. Glob. Womens Health 2022; 3: 823616. Doi: 10.3389/fgwh.2022.823616.
38. Reid HE, Pratt D, Edge D, Wittkowski A. *Maternal suicide ideation and behaviour during pregnancy and the first postpartum year: A systematic review of psychological and psychosocial risk factors*. Front. Psychiatry 2022; 13: 765118. Doi: 10.3389/fpsyt.2022.765118.

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