Ethical and medicolegal consideration in case of pregnancy due to sexual abuse in the schizophrenic patient

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ABSTRACT

Background: Pregnancy due to sexual abuse in schizophrenic patients always become a clinical problem in the obstetrics and gynaecology that can arise ethical dilemmas and medicolegal issues. Doctors must be able to balance between the obligation to protect patients from morbidity (nonmaleficience) and also respect the rights and decisions regarding patient reproduction (respect for autonomy). Ethical and medicolegal dilemmas can be resolved with consideration of clinical ethics namely indications of medical, preferential from the patient, life qualities and features of the contextual.

Case description: It is a case a 35-year-old patient diagnosed with Schizophrenia 4 years ago. Currently, the third pregnant patient due to sexual abuse (rape). In these conditions, there are two dilemmatic conditions, namely whether the patient continues the pregnancy with the risk that the baby will be born stranded or termination of pregnancy and carried out steady contraception?

Conclusion: The decision was taken to terminate and Pomeroy tubectomy as a contraceptive choice for patients with various considerations such as age, adequate children and especially chronic mental illness. Patients with problems like this are at risk of having a poor quality of life. Decision making for solid contraception is supported by the representative of the social ministry of the Republic of Indonesia and the patient’s family.

Keywords: ethical dilemma, medicolegal, pregnancy, schizophrenia, sexual abuse

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INTRODUCTION

In the last few decades, the development of medical science is progressing rapidly. The development of science must be accompanied by ethical studies so that medical services can be ethically justified. The issue of medicolegal dilemmas is increasingly diverse, especially in the fields of obstetrics and gynaecology. One of the ethical dilemmas is that need to be discussed is ethical and medicolegal to termination of pregnancy and contraception in schizophrenic patients who experience sexual violence.

Ethical dilemmas in a major way can happen to psychiatrists caused by the management of clinical from pregnant women with schizophrenia. In order to help the patient to prevent adverse consequences that possibly occur for herself and the pregnancy but also it is important to respect the patient’s autonomy is the challenges in this case. During the childbearing years for women, schizophrenia has a median age of assault.

Obstetric complications, a fetus with congenital malformations, and death in postneonatal with higher rates will be owned by pregnant women that have schizophrenia compared to general population. Losing custody of their children for adoption or foster care that gave to their family or child protective services perceived by lots of patients that carry their pregnancies through to term and the development of schizophrenia will be more likely brought by the schizophrenia progenies.

Nevertheless, there is a deficiency of literature about the issues related to ethical of schizophrenia management during pregnancy, especially pregnancy decisions termination management. There must be strategies for clinician especially mental health professionals and psychiatrists to help professionals managing the issues which are ethical during pregnancy that is treating psychosis. This matter was taken from the discoveries that impaired decision making can be manifest by the patients with schizophrenia to varying degrees from time to time. There is also the relevance of the concept from the patient who is the fetus and ethics strategies prevention has been described as well as assisted and decision making substitute so that the ethical conflicts can be prevented in the decision making which concerned about the pregnancy management for patients with schizophrenia.

The ethical analysis will be provided for this case by the authors. The framework will
be the vulnerability and the ethical response components which include: (1) establishing her vulnerability extents while decision-making capacity estimation process, (2) sharing decision making with a responsible substitute for mitigating the vulnerability. (3) reducing her vulnerability and treating her schizophrenia to restore limited autonomy. and (4) asking her substitute for informed consent and the assent of the patient to refuse her vulnerability.\

**CASE DESCRIPTION**

This report is about a 35-year-old woman diagnosed with schizophrenia since four years ago. This is her third pregnancy which happens due to sexual assault (raped). Based on the family patient was in ninth month pregnancy. Last Menstrual Period can not be confirmed. Antenatal Care was performed at the Obstetric and Gynecology department once at first trimester to confirm the pregnancy from ultrasonography. Other antenatal care was performed 3 times at midwife. She lives with her first son under supervision from her family living next to her house. The patient’s medical history revealed schizophrenia due to trauma caused by her divorce since 4 years ago. She had experienced multiple relapses and got treatment from a routine visit to the psychiatric unit included antipsychotics (haloperidol and trihexyphenidyl). The patient’s evolution had been spectacular with no relapses for two years. She is a housewife and only taking care of his son. She is not socially involved. The treatment had been administered and supervised during pregnancy by the family.

She presented in the Obstetrics and Gynecology Department under Social Department supervision with a complaint of water broke. The patient came with stabile hemodynamic with norm weight body. The generalised and obstetrical state was within normal limits. Laboratory findings showed anaemia microcytic hypochromic (Hb 9.3 gr/dL). Ultrasound examination was performed showing oligohydramnios supporting that there was water broke. She gave birth by cesarean section to a 3300 g healthy male baby with Apgar score 8/9. The procedure continued with tubectomy Pomeroy. She was discharged 3 days later and she had continued treatment. The baby was evaluated by a paediatrician at one month and then by a General Practitioner with normal developmental progress. The patient was in remission and she had continued treatment.

**DISCUSSION**

Medical decision making in this case, does not only pay attention to medical aspects but also must pay attention to aspects of clinical and medical ethics. Ethical considerations can be made based on clinical ethics theories from Jonsen, Siegler, and Winslade. According to clinical ethics theory from Jonsen, Siegler, and Winslade, 4 quadrants can be taken into consideration which is the indications of medical, preferential from the patient, life qualities and features of the contextual to make this theory is often called the four-box method.³

**Indications of medical**

The determination of indications of medical in these patients can be done using the principle of nonmaleficence and beneficence. The Beneficence principles mean that therapy must provide medical benefits, while non-maleficence means don’t harm the patient both medically and financially. Some related inquiries to medical indications: (1) What is the medical problem of the patient? What is the medical history? What is the diagnosis? How about prognosis? (2) Does the medical problem is critical?, chronic?, acute?, emergency? can still be cured? (3) What is the ultimate goal of the treatment? (4) What the success likely to be? (5) will there be the other plans if the therapy fails? (6) Besides, how does this patient benefit from medical treatment and how? loss from treatment can be avoided?.³

**Psychiatric Indication**

The literature shows that there are two groups od the indications of the psychiatric for the cesarean section. The first one is that a result of mental disorder history or pregnant women’s behaviour changes direct observation during the pregnancy entire course or in the period of antenatal. The patient’s inadequate behaviour with some psychiatric confusion such as psychotic or affective confusion even with retardation od the mental can bring up the question related to the capacity for the teamwork during work.³

The ability would be mainly assessed by the opinion of the psychiatrist in that case. Mental illness’s types and severities will determine this cooperations’ level. The course of labour improved control will be generated by the cesarean section delivery in some mental disorders cases such as mood disorders, psychotic disorders and anxiety disorders. The development of the perinatal complications caused during the labour by the extended labour as the effect of poor cooperations or the unforeseen psychosis exacerbation will be precautioned in the perinatal period.⁴

The next indication groups are tokophobia which is the labour strong fears attendances. This anxiety type comes up usually with women that
have other anxiety disorders types such as having panic disorders or generalised anxiety disorders or anxiety that occurs in the course of the depressive disorder. The literature did not characterise tokophobia types that reduced by psychoeducation or psychotherapeutic intervention effectively. The National Institute of Health and Care Excellence (NICE) guidelines in 2013 have published the tokophobia’s most practical features represent the cesarean section indications that is absolute.⁸

Obstetric Indication

Mental health of pregnancy and puerperium period specialist should consult any pregnant woman who has fear for delivery symptoms based on clinical standards. Consultation about the medical consequences and delivery methods should be offered to the pregnant woman before the consultation is carried out.⁹ The NICE guidelines stated that the cesarean section should complete the pregnancy if vaginal delivery did not accept by the pregnant woman with tokophobia even after some sessions of psychoeducational has been done.

Women with serious mental illness such as schizophrenia or bipolar disorder have none polish data about deliveries preferred modes. Nevertheless, the risk of the complications for schizophrenia women related to the pregnancy and childbirth will liven up. Perinatal complications are part of schizophrenia risk factors has been proved.⁷

Exposing ‘medicalisation’ of vaginal delivery such as labours pharmaceutical induction that resulted in perinatal complications of the women medicate for psychosis should be reviewed whether it is increasing psychosis risks for children born from that kind of deliveries. Furthermore, women that previously treated for psychosis will have twice higher complications risk for the pregnancy and the childbirth, whether the risk for premature birth or low weight for newborn birth. So, patients with psychosis histories need higher attention from obstetricians and psychiatrists.⁸

Mental disorders which are major experienced by the patients which include schizophrenia are sustaining higher risk for coerced or forced into intercourse in sexual if it is compared to the other groups. The possibility of having HIV-positive should be aware by the psychiatrists and also it is needed to be zealous in searching the other factors that redound to psychosis and even the decision-making capacity will be impaired, after that it is needed to seek for the reversible impairments creation. More time that given to her might be unlikely to succeed in our perspective, this is because of the cognitive understanding in severe impairment and the evaluative understanding of the patient will be limited by the appreciation.¹

Anaesthetic indication

The increasing number of pregnant women with schizophrenia has required obstetric anaesthesia care. Preoperative evaluation in patients with psychiatric illnesses must be adjusted to the type and severity of mental disorders. Patients with stable mental status can be performed with regional anaesthesia because the benefits of the technique are well known during obstetric anaesthesia. However, the choice of anaesthesia technique must be active depending on the mental status of the patient, in an unstable mental state it should be done with general anaesthesia.⁹

In the case of pregnancy termination through cesarean section surgical procedures, clinical ethics in terms of anaesthesiology must also be considered. In this case, informed consent for anaesthesia must be obtained from the patient’s family. In the approval of the medical procedure, it was stated that the type of anaesthesia to be performed was general anaesthesia. The selection of general anaesthesia is different in the Caesarean section which generally uses regional anaesthesia (spinal anaesthesia). General anaesthesia in schizophrenic patients using endotracheal intubation. In obstetric anaesthesia, three principles must be considered, namely: 1. Save the mother, 2. Save the baby and 3. Save the uterus. So in this case, the selection of general anaesthesia to save the mother from increased intracranial pressure and intraoperative safety in avoiding exacerbation of schizophrenia so that the operator can easily remove the baby.

The principle of general anaesthesia in obstetric action to save the mother by giving a type of induction drug that does not generate schizophrenia and does not increase intracranial pressure such as ketamine which is contraindicated. Previously, patients with schizophrenia had to be given a midazolam premedication drug with good cooperation with the operator in the process of removing the baby to cut the umbilical cord to be completed in less than 8 minutes. All inhalational anaesthetic agents cross the placental barrier and are associated with neonatal depression. The time between induction and birth should ideally be accelerated when using general anaesthesia. Exposure reported for more than 8 minutes is associated with neonatal depression.¹⁰

Preferential from the patient

The preferential from the patient and or their families are served by using the autonomy principle. Autonomy means that every medical action must be approved by a competent patient (or his immediate
family, if the patient cannot give his consent). Some patient requests questions appear as follows: (1) does the patient legally declared competent and capable of mental? Are there circumstances that cause inability ?, (2) If they do, how this options of the treatment in their perspective?, (3) Has the patient been informed of the benefits and risks, understood or not the information provided and gave consent?, (4) If not competent, who should replace it? Does the competent person use the appropriate standards in making the decision?, (5) Does the patient show something he likes more ?, (6) Is the patient unwilling/unable to cooperate with the treatment given? if so, why? (7) Also, what is the patient's right to choose to be respected regardless of ethnicity or religion?.

As long as they can be reliably identified, ethical and medicolegal standards of substitute assessment for substitute decision-making require that decisions based on the information about the patient's old values or preferences made for patients. Which means, the surrogate must make the patient's decision to make the patient able to do it as far as possible. However, patient values may be unknown or cannot be found, or may not be held consistently over time. The best interests of the standard must guide the decision-making replacement, that is, identifying clinical management that protects and improves patient health for this case. The physicians should identify a legally appropriate replacement decision maker. Approval of medical measures must also be following the rules of medicolegal, as stated in article 45 of the Republic of Indonesia Law No. 29 of 2004 concerning medical practices which states that parents can do the signing of an informed consent, guardians, immediate family or parent host if the patient is not competent to give consent.

The thing that needs to be clarified is whether psychosis might affect a patient's ability to make this decision and might interfere with his ability to participate legally in the consent process that informed. It is very important for the obstetrician along with the psychiatrist that the extent of the influence of psychosis on this decision to be evaluated because the doctor is obliged to respect the autonomy by recognising the values and beliefs of the patients, by displaying his preferences, and by bringing out those preferences (unless there are reasons ethical force for the contrary). Also, doctors are required by the principle of virtue to seek a balance of goods greater than the dangers of caring for pregnant women and fetal patients, as assessed from a clinical perspective that is knowledgeable and thorough or based on evidence. Thus, doctors must also consider the possible adverse effects of psychosis on pregnant women and fetuses. Firstly, the patient must be able to attend, absorb, maintain, and recall information disclosed to join in the process of the consent informed. The psychiatrist providing the information to patients in languages that the patient understand and at a speed that the patient can manage is a must.

Patients need to reason from current events for their possible future consequences, called cognitive understanding. This consequence needed to be understood by the patient that it might happen to her. Appreciation is the name. The assistance should be given to the patient so she can evaluate the consequences from her values and beliefs which have the aim to reach an understanding than evaluative. The patients should be helped by the clinician to achieve, appreciation, cognitive understanding also evaluative understanding so at the end, they could communicate the voluntary decisions based on this understanding types.

In the previous study, we have argued that the ability of patients to participate in one or more of these steps may be impaired chronically. Also, for schizophrenia patients or depressive disorders, this decrease can vary over time, which results in a phenomenon which we call chronic and variable autonomy disorder.

In our perspective, autonomy with chronic and varied disorders concepts has some important implications for the cases reported above. First, the potential area of the patient's deficit in participating in the informed consent process must be measured. A patient's said that a “bad vibration” experienced by the patient, that may be related to her experience that increasingly rapid and may reflect a lack of a simple understanding of this phenomenon. Patient's attention can be distracted by the auditory hallucinations when it presents the same as the attention and absorption, retraction, or information retention. Hearing hallucinations can damage evaluative understanding and volunteerism when they instruct them to injure themselves or the fetus or to pregnancy's terminate or continuation.

The second implication which is very important regarding the chronically and varied autonomy that impaired is that revokable barrier to the exercise of patient autonomy must be identified and overcome. Educational strategies, treatments, and psychosocial interventions like problem-solving in teaching strategies and training in communication skills make it possible to overcome obstacles in implementing autonomy and are assisted decision making. For example, education contribution to improving anxiety of the patient about accelerating experiences. The education about their disorders, how they contribute to difficulties in decision.
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making can also be given to the patients. The interventions of education which include the improved feedback, trials of the multiple learning, and the simplification or organisations of some key elements in the form of consent - can overcome a deficiency in understanding.¹

Treatment is an important response to disturbed decisions caused by paranoia as auditory hallucinations. The identification of a small increase in congenital malformations risks with low antipsychotic drugs potential has been released, even though potentially higher antipsychotic agents are known a little, the potential benefits and the potential risks must be considered together.¹

Decreasing the psychosocial pressure and the likelihood of future disease episodes, also contributing to the stability of their beliefs and values, and increasing their ability to become more effective advocates for their preferences for the patients can help the patients by the communication skills training and problem-solving strategies. Autonomy disorders treatment can also include treatment of physical illness or substance abuse simultaneously when the condition is related to the disorder.¹,¹¹,¹³

For this case, decision changing might be related to the emergence of the paranoid feeling about the fetus, which reflects the variability of the autonomy disorder. Another identical and not usually scenario can happen whenever a pregnant woman with schizophrenia changes her mind and decides not to take medication. Whether a patient changes her decision due to psychotic decompensation which means due to undue paranoia and an overestimation of the possible adverse consequences of drugs for pregnancy can be determined by the assessment.¹,¹¹,¹³

Life qualities

Measurement of life qualities is determined using the principles of autonomy, nonmaleficence and beneficence. Life qualities is a form of satisfaction, a statement of value, life experiences in all aspects for better or worse.¹ Some questions related to life qualities: (1) What are the prospects to return to normal life for the patient with or without treatment?, (2) If the treatment is successful, how about the physical, psychological, and social disorders that the patient experiences?, (3) Are there any prejudices that might raise suspicion about the service provider's evaluation of the patient's quality of life? can be assessed as expected ?, (5) Are there rational rationale plans for further treatment?, (6) Are there plans for palliative care?³

In the perspective of ours as the researchers, in priority cases about the management, it is must help pregnant women by inviting her to consider previous values regarding pregnancy and becoming a mother. The woman can then be helped for a decision, considering her values, and use the assisted decision-making principles as described above. In part of the other cases, it is even possible and appropriate for a doctor to ask a patient when relatively undisturbed in the decision-making capacity by psychosis to state her choice of pregnancy outcome, given the possibility of the level of paranoia or psychosis for further increase. That kind of statements are in the form of a "Ulysses contract" which is approval for actions to avoid the risks given when patient making a decision is relatively undisturbed can be used for situations where decision making can become more disrupted.¹,¹⁴-¹⁶

Ulysses contracts are not legally binding and revokable, and every time a pregnant woman has to be assumed to have adequate decision-making capacity. By reminding patients of previous preferences, the Ulysses contract helps to increase their decision-making capacity. This decision-making strategy with assistance is intended to prevent patient decisions about pregnancy that cannot be justified to avoid the consequences for possible adverse. Decision making is helpful in our view because it serves to prevent the control of patient decision making by doctors, family members, and unreasonable institutions. Assisted decision-making also helps counter the possibility that initial views or preferences expressed by patients will be interpreted as authoritative as if they were based on a patient's pre-existing beliefs and values.¹,¹⁴-¹⁶

The high number of pregnancies among women which are unplanned and unwanted with lower-line schizophrenia is the importance of comprehension of family planning includes the attitudes and practices. Many chronic mental diseases that women do not have basic contraception knowledge. Family clinics planning which is standard may be less familiar with the problem of how schizophrenia is affected by informed consent. "Ulysses contract," where a woman gives consent when she is most stable and shows that she wants her agreement remaining valid if she later becomes crazier, it might help. Offering psychosocial skills training to decrease unwanted sex and understanding the way mental illness can influence contraceptive choices should be offer by the mental health professionals.¹⁴-¹⁶

In this case, we decided to perform Tubectomy Pomeroy as family planning for the patient due to some consideration such as age, enough child and especially chronically mentally ill. The patient with this problem must have poor quality of life. The
decision making of sterilisation was supported by her family and the representative from Social Ministry of the Republic of Indonesia in Banda Aceh.

Features of the contextual
Features of the contextual are obtained by using the principles of justice and fairness. Some questions related to features of the contextual: (1) Are there family problems that might influence treatment decision making?, (2) Are there any data source problems (clinicians and nurses) that might influence treatment decision making?, (3) Are there financial problem issues and economics?, (4) Are there religious and cultural factors? (5) Are there limits to belief? (6) Are there resource allocation problems? (7) How does the law influence treatment decision making? clinical research or learning involved?, (9) Are their conflicts of interest in the decision making section of an institution?.

A conscientious evaluation of their capacity in being a parent in the future is needed as an effort for identifying the deficiency that possibly occurs in advance also to improve them thru education, supports in social section, and training. The appreciation by the clinician should be given that even due to abuse or neglect they lose the custody of the children, evaluating childcare competencies are rarely done clearly, and some mothers may successfully raise subsequent children. After the birth of a child, maternal competence evaluation requires investigations that are sensitive and non-judgmental of the mother’s behaviour and thoughts, with data collected from various sources.

In the perspective of the researchers, and ethics preventive strategy should be adopted by the obstetricians, with the participation of the colleagues in psychiatry for discussing management of intrapartum in advance to increase patient autonomy in the future. This discussion can present various alternatives for labor and delivery management. These alternatives can then be obtained about the patients’ values, together with alternatives of the evaluative understanding and preferences using value-based. These preferences of the appropriate management plan must be negotiated. The patient must also be educated about convincing and acute indications from the fetus or mother who needs labour by cesarean section.

Doctors must consider aspects of clinical ethics in practice. Doctors must be able to balance the obligation to protect patients from morbidity (beneficence-nonmaleficence) and respect the rights and decisions regarding patient reproduction (respect for autonomy). The pregnant patient’s clinical management for suffering from schizophrenia can be very hard to accomplish if the decision making is disrupted. Disturbances in decision making steps, especially in appreciation, cognitive understanding, and understanding the evaluative, must be identified. Preventive ethics and decision-making strategies of the medicolegal that are assisted the patients overcome variable autonomy disorders and various chronic disorders in psychosis.

CONCLUSION
An important alternative about the assisted decision making to give an ethical responsibility for the problematic things for taking the patient’s decision making over and treating patient about pregnancy and its management as authoritative decisions. Replacement decision-making that standards will be applied when the patient is very disturbed in decision making. The obstetricians might have a strong sentiment about the problems for pregnant women with schizophrenia at stake, both regarding her pregnancy management and health, and about their ability to be sufficient parents of the children.

Obstetricians can clearly experience such a frustration when inconsistent attitudes exhibited by the patients and views about the problem which staked or predict the patient’s ability to make decisions that are safe for the fetus as a patient and expected child. Clinical judgment can sometimes released by a strong intention and the application of assisted decision-making strategies. Responding to these strong feelings, it is must be aware that most schizophrenia patients can successfully raise children, especially adequate supports, are given. In the end, chronically disturbance addressed and diverse autonomy has a goal to support the prerogative of women based on autonomy to make wise and informed decisions.

CONFLICT OF INTEREST
The authors declare there is no conflict of interests.

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AUTHOR CONTRIBUTION
TS as an ethics-medicolegal consultant, he is responsible for the ethical and medicolegal consideration in the case and final editing in the manuscript preparation. FR as candidate of obstetrician and gynaecologist, she is responsible for the ethical and medicolegal consideration in the case and final editing in the manuscript preparation. FR as candidate of obstetrician and gynaecologist, she is responsible for the ethical and medicolegal consideration in the case and final editing in the manuscript preparation. K as anesthesiologist and candidate of neuro-
anesthesiology consultant, she is responsible for English improvement and the management of anaesthesia.

REFERENCES:

1. Coverdale JH, McCullough LB, Chervenak FA. Assisted and Surrogate Decision Making for Pregnant Patients Who Have Schizophrenia. Schizophrenia Bulletin. 2002;30(3):659–664.

2. Dudzinski DM, Sullivan M. When Agreeing with The Patient is not Enough: A Schizophrenic Woman Requests Pregnancy Termination. General Hospital Psychiatry. 2004;26:475–480.

3. Jonsen AR, Siegler M, Winslade WJ. Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine Book 7th ed. The McGraw Hill Companies. New York. 2010: 9-159.

4. Holka J, Ja M, Artur S, Piróg-b A, Wi A. Elective Cesarean Section on Psychiatric Indications – The Phenomenon Analysis, Report of Two Cases and Psychiatric Clinical Recommendations. Psychiatr Pol. 2016;50(2):357–373.

5. National Institute of Health and Care Excellence. NICE Quality Standard [QS 32]. http://www.nice.org.uk/guidance/qs32/chapter/introduction-and-overview [retrieved: 27.01.2016].

6. Subair S, Osbourne A, Wilson S. PLD.50 Maternal Request Caesarean Section: 2 NICE Pathways? Arch. Dis. Child. Fetal Neonatal Ed. 2014; 99(Suppl. 1): A121.

7. Suvisaari JM, Taxel-Lassas V, Pankakoski M, Haukka JK, Lonnquist JK, Hakkinen IT. Obstetric complications as risk factors for schizophrenia spectrum psychoses in offspring of mothers with a psychotic disorder. Schizophr. Bull. 2013;39:1056–1066.

8. Nilsson E, Lichtenstein P, Cnattingius S, Murray RM, Hultman CM. Women with schizophrenia: pregnancy outcome and infant death among their offspring. Schizophr. Res. 2002;58(2–3):221–229.

9. Cok OY. Anaesthesia for Pregnant Patients with Psychiatric Disorders. Obstetric anaesthesia for co-morbid conditions. Springer Link. 2018: 145-154.

10. ACOG Practice Bulletin No. 36. Obstetric Analgesia and Anesthesia. American College of Obstetricians and Gynecologists. 2002;100:177-191.

11. McCullough LB, Coverdale JH, Chervenak FA. Ethical Challenges of Decision Making with Pregnant Patients Who Have Schizophrenia. Am J Obstet Gynecol. 2002;22:696–702.

12. The Indonesian Republic. Article Number 29 of the Indonesian Republic Regarding Medical Practise; 2004.

13. Sastrawinata RS. Ethics in Obstetrics and Social Gynecology. In: Martaadisoebrata D, Sastrawinata Hospital, Saifuddin AB (editor). Obstetrics and Social Gynecology. 1st edition. Jakarta: Bina Pustaka Sarwono Prawirohardjo; 2005. p. 127-132.

14. Miller LJ. Sexuality, Reproduction, and Family Planning in Women with Schizophrenia. Schizophrenia Bulletin. 1990;23(4):623–635.

15. Miller LJ, Finnerty M. Family Planning Knowledge, Attitudes and Practices in Women with Schizophrenia Spectrum Disorders. Am J Obstet Gynecol. 1998;28:210–7.

16. McCullough LB, Coverdale J, Bayer T. Ethically Justified Guidelines for Family Planning Interventions to Prevent Pregnancy in Female Patients with Chronic Mental Illness. Am J Obstet Gynecol. 1991;167(1):19–25.