The Ethics Dispatch

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"Functioning as our better selves leads to better outcomes for patients and everyone."

-- Tarris (Terry) Rosell, PhD, DMin, HEC-C

Hot Topic

The Ethics of Maternal Mental Healthcare:
When Asking for Help Feels Dangerous

By Cassandra Shaffer Johnson, MA, Program Director of Ethics Services

The Lindsay Clancey case has raised questions about what happens when pregnant and postpartum women disclose mental health issues.

We have all been there as patients. Feeling vulnerable, a tad awkward, perhaps a little cold, sitting on an exam table in a thin gown under unforgiving fluorescent lights. Then comes the knock, followed by a healthcare professional carrying a folder containing our confidential health information. And then come questions that most people would never ask a stranger: Are you using drugs? Do you feel safe at home? Are you thinking about suicide? Have you thought about hurting someone else?

Although awkward and maybe even uncomfortable, these questions are asked because the answers matter. They matter greatly. But honesty requires something in return. Patients must believe that telling the truth will lead to help rather than admonishment or punishment. For some mothers experiencing postpartum mental health conditions, that trust can be remarkably difficult to give.

Like Banging Her Head Against a Brick Wall

In light of the recent Lindsay Clancy case, a recent CNN article was published examining maternal mental health. The article briefly describes the experience of Adrienne Griffen, who sought help for severe postpartum depression after the birth of her second child in 2001.

When she spoke with her physician, she was abruptly warned that Child Protective Services would be contacted if she harmed her children. When Griffen explained, “I am here to get help, so I don’t hurt my children,” the physician reportedly responded, “Well, we don’t want another Andrea Yates.” It took Griffen another six months to receive the help she needed. “It was like banging my head against a brick wall,” she said. To anyone who has shared motherhood and parenting horror stories, this is not shocking at all.

Twenty-five years later, maternal mental health is discussed far more openly, but the ethical problem underlying Griffen’s experience remains, and the system hasn’t come close to catching up. In fact, as stated by Dr. Burkhard in the article, current obstetrics care is based on a billing system structure that was “created 30 years ago.” (Mascarenhas 2026.) Billing system structure. Let that sink in.

Creating a Safe Environment Before Danger Arises

How can healthcare professionals protect children from genuine danger while creating an environment in which mothers feel safe enough to disclose frightening thoughts before they become a crisis? How can we treat mothers with the respect and compassion they deserve? How can both healthcare professionals and patients navigate a broken system structured around billing and not always structured around actual care?

It is tempting to frame this primarily as a conflict between autonomy and beneficence. Healthcare professionals have an obligation to respect patients’ privacy and self-determination while also acting to prevent serious harm. When there is an imminent threat to a child, intervention may be ethically and legally necessary.

But focusing only on what clinicians should do once danger is apparent misses an important question: What kind of healthcare environment are we creating before we ever reach that point?

Fear and Stigma Create Barriers to Disclosure

Maternal mental health conditions are not unusual. According to the article, mental health issues such as depression and anxiety affect as many as one in five women during pregnancy or the year following childbirth. As a mother myself, I can attest that sleep deprivation alone can exacerbate any rough edge in a person’s mental health, and feelings of failure can be very real. Motherhood can feel like a very lonely thing.

For some mothers, however, mental health symptoms can become far more severe. Postpartum psychosis is considerably rarer, affecting up to two of every 1,000 women after childbirth. Yet across maternal mental health conditions, fear and stigma remain powerful barriers to disclosure. Women may worry not only that others will think they are bad mothers, but that admitting what they are experiencing could result in separation from their children.

That creates an ethical paradox. The healthcare system needs patients to disclose disturbing thoughts so clinicians can evaluate risk and provide appropriate treatment. But if patients believe disclosure itself is dangerous, they have a powerful incentive to remain silent. Fear of losing your family can create even greater feelings of anxiety and depression, thus exacerbating the underlying issue. Simply put, a system theoretically designed to protect children can inadvertently make it harder to identify the mothers and families who most need help. A system ostensibly created to protect might actually harm, whether intentional or not.

Harms Created by the Healthcare System

Nonmaleficence, the obligation to avoid harm, therefore requires more than preventing an immediate tragedy. **It also requires considering harms created by healthcare systems themselves, for example:**

- A dismissive comment
- An unnecessarily threatening explanation of mandatory reporting
- Outdated care structures based on billing requirements
- Screening programs without meaningful access to treatment

Any of these can discourage future disclosure and increase severity of mental health issues.

Screening alone is not enough. As the article notes, professional guidelines exist for screening pregnant and postpartum patients for mental health conditions, but implementation remains inconsistent. Even when clinicians identify a problem, patients may encounter long waits for therapy and limited referral options. A mother may sit on a waiting list while in a state of crisis – and if that isn't a failure of the system, I don't know what is.

Two Responsibilities for Healthcare Professionals

So this raises the question of justice as well. If healthcare institutions routinely ask patients to disclose deeply personal information, they must assume responsibility for ensuring that meaningful care exists when the answer is, "Yes, I need help."

Maternal mental healthcare therefore asks healthcare professionals to hold two responsibilities simultaneously:

- **to take genuine threats to children seriously,**
- **while making clear that experiencing depression, anxiety, intrusive thoughts, or other symptoms does not automatically make someone a dangerous parent, nor does it make someone a "bad parent."**

Those responsibilities are not opposites. In fact, they depend on one another. A mother who says, "I am afraid of what I am thinking," should not have to calculate whether honesty will cost her her family before deciding whether to ask for help.

If we want patients to tell us the truth when the truth is frightening, healthcare must first demonstrate that telling the truth is safe.

Sources

Maternal mental health is making headlines. Experts say it's long overdue

Bioethics in the News

[8 Crucial Bioethical Quandaries Gene Editing Investors Must Grasp](#)
The Tech Edvocate

[Landmark pig kidney transplant sparks massive bioethics divide](#)
msn

[Imagining bioethics with Emily Dickinson: a poetic exploration of the art of dying](#)
BMJ Journal

Case Study

Hospital Denies Parents' "Right to Try" Request:
Chloe's Doctor Doesn't have Medical Privileges

Chloe Jatz is a six-year-old female who has suffered from a rare genetic condition her entire life. Her lungs continue to be damaged by her immune system as she struggles with respiratory issues. She has required supplemental oxygen her entire life and has needed to be intubated several times during respiratory crises. Her parents, Jacob and Diana, have been with her through all of her struggles and are constantly engaging with physicians and experts across the world.

Chloe is currently intubated after experiencing a respiratory event and has been in the hospital for several days. She is moderately stable, but the medical team worries that another such event could leave her requiring mechanical ventilation for the rest of her life.

Mr. Jatz has recently learned of a new experimental treatment for patients with Chloe's condition. The treatment has shown some success in animal testing but has not been approved for human trials. The primary investigator for the new treatment, Dr. Duckman, lost his medical license in the United States several years ago due to overly aggressive actions in research and has since been practicing and conducting research outside of the United States. Dr. Duckman is willing to travel to Chloe's hospital to administer the treatment.

The hospital denied this request, stating that Dr. Duckman does not have medical privileges or a license and cannot perform an experimental treatment on Chloe in the hospital. The Jatz family has petitioned under "Right to Try" legislation to gain access to the treatment and is demanding that the hospital allow Dr. Duckman to administer it to Chloe. They have been aggressively posting on social media, and a "media circus" has developed around the situation. The hospital has asked the hospital ethics committee to comment.

Ethical Musings

It's Not about Guilt:
What Matters Ethically in the Lindsey Clancey Case

By Ryan Pferdehirt, D.Bioethics, HEC-C, Vice President of Ethics Services, Rosemary Flanigan Chair

There has been a constant flow of opinions, comments, and discussions about the Lindsay Clancey case. It has served as a jumping-off point for conversations about important topics that are not commonly discussed, such as postpartum maternal mental health and patient-provider relationships. But more often than not, these conversations devolve into gossip and speculation, which can obscure some of the important issues the case can help illuminate.

When learning about a tragic event, it is normal for people to mentally place themselves in the situation and imagine what they would do. We may think to ourselves, "If I were in that burning building, I would have just jumped out the window and taken my chances." Or "If I were on that sinking ship, I would have been able to swim the miles to shore." Or "If I were that mother, I would never have murdered my children."

Case Studies Provide Real-World Grounding

Thinking about what you would do in a given situation is a completely natural approach to working through complicated circumstances, and it can be an effective way of engaging with bioethics topics.

Many people who are unfamiliar with the concepts of bioethics can find the field difficult to navigate. Where do you even begin when thinking about the morality of modern medicine? This is why the field often utilizes paradigm, or particularly meaningful, case studies that provide real-world grounding.

These might include the cases of Nancy Cruzan, Terri Schiavo, or Jahi McMath. These were real people who suffered terrible tragedies, but their situations touched on important issues that others can learn from. These cases can be fascinating and deeply engaging, and they are a common way that people are exposed to the field of bioethics for the first time.

Real People Experiencing Terrible Suffering

But while these situations can offer important lessons that go on to help others, it is important not to forget the underlying fact that these were real people who experienced terrible suffering. The central element often missing from these thought experiments is the human one.

While the Jahi McMath case raises deeply challenging questions regarding brain death and the boundaries between life and death, what can become lost in discussions of the case is the fact that a thirteen-year-old girl lost her life. It is one thing to use the lessons of a situation to learn and improve healthcare; it is another to use a tragedy to further one's own aims. We should never lose sight of the fact that these lessons arise from situations we would rather have never occurred. While the lessons Jahi McMath taught us are valuable, they are not more valuable than Jahi herself.

Bioethicists tend to understand this distinction and show the necessary respect for the individuals involved, but others in our culture are not always as conscientious. This can make some bioethicists hesitant to discuss these cases publicly, not wanting to upset the wrong person or say the wrong thing.

What Healthcare Can Learn from Lindsay Clancey

When I think about the Lindsey Clancey case as a whole, I have little interest in whether she was guilty or not. Instead, I feel only sadness that the situation happened at all. I personally believe that people's instinct to assign blame and guilt stems, at least in part, from our ongoing need to make sense of a senseless world.

There are things the healthcare industry can learn from the Lindsay Clancey case, but not at the expense of recognizing the underlying human tragedy. We should strive to be mindful ethicists, rationally and consciously addressing the lessons and concepts raised by the case without becoming consumed by courtroom drama, relationship gossip, or ad hominem judgments. We should approach these situations with empathy and compassion rather than a personal agenda or a political point to prove.

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