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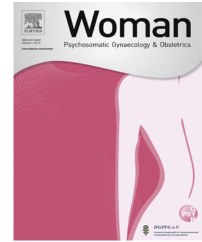

REVIEW

Ethical considerations of screening for mental health disorders during periodic well-woman exams

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Summary Mental health concerns, particularly depression and anxiety, are common among women of all ages. Because obstetrician/gynecologists (ob/gyns) often serve as a primary source of care for women, they are in a unique position to detect and target mental health symptoms early. In this context, we define ethics as the balance between one's competency in practice, and the need to treat patients with conditions outside of that competency. This paper discusses the ethical challenges that ob/gyns may face in identifying and treating mental health conditions due to lack of expertise, training, and experience. We also focus on the ethical considerations that favor interventions on the part of ob/gyns, and how improved training could help to resolve this ethical dilemma. In addition, the expansion of collaborative care networks may help to build continuity of care.
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1. Introduction

As increased attention is paid to completeness of care, awareness of the finite aspect of both practice and knowledge is brought into perspective. In this evolving system, obstetrician/gynecologists (ob/gyns) shoulder increasing responsibilities in the provision of well woman care. Efforts to identify and treat a multitude of complaints means that ob/gyns may feel overburdened or underqualified in coping with the presentation of certain symptoms or conditions.

Within this context, a greater sense of the impact of mental health disorders has pushed mental health screening and interventions into a growing list of priorities for providers who care for women. Ob/gyns may feel pressured to recognize and treat signs of mental health disorders, but may not feel they have the knowledge or skills to effectively manage these conditions (Park et al., 2005). This can lead to ethical conflicts in which practitioners feel drawn to provide necessary services, but are not sure they have adequate competencies.

In this paper, we discuss women's mental health and best practice for basic mental health screenings. We discuss the ethics of refusing mental health treatment in the context of obstetrics and gynecology due to lack of expertise, versus providing care when patients may not have access to psychiatric care. We describe practical approaches to education and practice that may help to resolve these conflicts while providing quality care for patients.

To this effect, we conceptualize medical ethics from a consequentialist perspective. This means that ''ethics is to bring about our (a) informed, (b) human wants and likes (c) deliberately (d) on the basis of inquiry (e) with as adequate and full consideration (f) as reasonably possible (g) of naturalistic and global consequences for everyone... (Maier and Shibles, 2011, p. 123)'' In particular, we focus on the need to provide mental health care in the face of the suffering caused by the scarcity of such care to both the individual and the collective (Mill, 2002). We consider these factors and how mental health practices among women's healthcare providers might fit into a rational and holistic conceptualization of medical ethics (Maier and Shibles, 2011).

2. Women's mental health

Mental health disorders including depression and anxiety are more prevalent among women than men (see Table 1; Kessler et al., 1993; Eaton et al., 2012). Diagnoses such as psychosis and paranoia may be present in cases of anxiety or depression. All of these conditions can have serious and life-altering impacts on those who experience them.

Mental health conditions are linked with reduced productivity, decreased quality of life, and increased physical health complaints. Depression in particular has been linked to reproductive phases in women such that rates may be higher around menstruation, childbirth, and menopause (e.g., Hill et al., 2005; Marcus et al., 2003; Parry, 2008). Perinatal and postpartum periods have been linked with particularly high risk for the development of mental health disorders (see Table 2; Marcus et al., 2003; Munk-Olsen et al., 2006). During these times, changes in social roles,

Table 1 Disorder prevalence rates and odds ratios by gender.

	Lifetime disorders			12-Month disorders		
	Women (%)	Men (%)	Odds ratio	Women (%)	Men (%)	Odds ratio
Depression	22.9	13.1	1.46 (1.41–1.51)	10.1	5.5 (1.32–1.45)	1.38
Dysthymia	6.2	3.5	1.31 (1.25–1.38)	2.9	1.6 (1.20–1.39)	1.29
Generalized anxiety	5.8	3.1	1.34 (1.27–1.42)	3.1	1.4 (1.28–1.47)	1.37
Panic disorder	7.2	3.7	1.39 (1.32–1.47)	3.1	1.4 (1.29–1.49)	1.39
Social phobia	5.8	4.3	1.16 (1.10–1.22)	3.4	2.1 (1.15–1.29)	1.22
Specific phobia	12.4	6.2	1.47 (1.41–1.53)	9.6	4.6 (1.40–1.53)	1.46
Alcohol dependence	8.0	17.4	0.63 (0.60–0.65)	2.3	5.4 (0.64–0.72)	0.68
Nicotine dependence	15.6	20.0	0.84 (0.81–0.87)	11.5	14.1 (0.85–0.91)	0.88
Marijuana dependence	0.9	1.7	0.77 (0.71–0.83)	0.2	0.5 (0.63–0.83)	0.72
Other drug dependence	1.4	2.2	0.84 (0.79–0.90)	0.3	0.5 (0.72–0.95)	0.83*
Antisocial personality	1.9	5.5	0.68 (0.59–0.66)			

Eaton et al. (2012).
Note: All ORs significant at $p < .001$ except $^{*}p = .005$.
Men are OR comparison group. 95% confidence intervals are given in parentheses. Antisocial personality disorder was only assessed as a lifetime disorder.

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