Contraception and the age of consent

The role of the GP

DEBORAH BATESON MB BS, MA(Oxon), MSc(LSHTM)
KATHLEEN McNAMEE MB BS, FRACGP, DipVen, GradDipEpiBio, MEpi

Adolescents may present seeking contraceptive advice without parental consent and GPs must decide if the patient has the capacity to fully understand the advice given.

Case scenario

Josie has just turned 15 years of age and has a 16-year-old boyfriend whom she has been seeing for two months. She has recently been sexually active with him and comes to see you requesting the 'morning after pill'. Josie had sexual intercourse two days ago and wants to know about her risk of pregnancy and whether she can start taking the oral contraceptive pill at her age. Her last period was 20 days ago and she has a 28-day cycle. She says that neither she nor her boyfriend have had previous sexual experiences. She says her relationship is 'serious' but she has not told her mother about it.

How should the risk of pregnancy after having the morning after pill be explained to Josie? Does the GP have a duty to tell Josie's mother about this consultation? How should the legal issues of Josie being underage best be approached?

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Associate Professor Bateson is Medical Director of Family Planning NSW; and Clinical Associate Professor in the Discipline of Obstetrics, Gynaecology and Neonatology at The University of Sydney, Sydney, NSW. Dr McNamee is Medical Director of Family Planning Victoria; and Adjunct Senior Lecturer in the Department of Obstetrics and Gynaecology, Monash University, Melbourne, Vic.

Commentary

Josie has made the mature decision to seek the 'morning after pill', now referred to as the emergency contraceptive pill (ECP), due to her risk of unintended pregnancy. You explain to Josie that the riskiest time in the menstrual cycle to become pregnant is in the time leading up to and just after ovulation. This is because sperm survive for up to seven days in the upper genital tract and the egg survives for up to 24 hours after its release. However, the timing of ovulation can be very unpredictable and therefore emergency contraception is advised anytime in the menstrual cycle if unprotected intercourse has occurred.

During the consultation, you find out that Josie is attending school and consumes alcohol occasionally. She says she and her boyfriend use condoms intermittently and that she has never been pressured or coerced into having sex.

The law in relation to the age of consent differs across Australian states and territories. Although having sex with a person under the age of 16 years (or 17 years in some states) is technically a crime, a 'similar-age' defence exists in some Australian jurisdictions. For example, in NSW the law allows for sex between consenting minors aged 14 years and above where there is no more than a two-year age difference.

Mandatory reporting and competency

As a GP and mandatory reporter you have a duty to inform the relevant authorities of any young person at risk of significant harm. In the current case, you ascertain that Josie is not at risk of harm and is acting responsibly in seeking emergency contraception and advice.

You must also assess that Josie is 'Gillick competent' and has

the capacity to understand the information you provide about the various emergency contraceptive options. Should you make the decision that she is a mature minor you are legally able to prescribe contraception for her without parental consent.

You ask Josie about her relationship with her mother and find out that she has a good relationship with both her parents. Although you reassure her that the consultation with you is confidential and that you will not inform her parents of her visit, you also encourage Josie to talk to her mother about her relationship. Good documentation of the points discussed is essential.

Should you make the decision that [Josie] is a mature minor you are legally able to prescribe contraception for her without parental consent.

Emergency contraception

You inform Josie that there are three types of emergency contraception available – the levonorgestrel (LNG) ECP (effective up to 96 hours after unprotected sexual intercourse), the ulipristal acetate (UPA) ECP (effective up to 120 hours after unprotected sexual intercourse) and the copper intrauterine device (IUD; effective up to 120 hours after unprotected sexual intercourse). You advise her that the ECPs decrease the chance of a pregnancy by about 85%, whereas the copper IUD is about 99% effective.

Josie is not keen on a copper IUD as it seems a bit of a 'big leap' at this stage. You discuss the pros and cons of the two types of oral ECPs and explain that they both work by preventing or delaying ovulation. Although the LNG ECP is the cheapest option, evidence suggests it is less effective than the UPA ECP. Also, the efficacy of the LNG ECP appears to be affected by weight and although evidence for improved efficacy is lacking a double dose (3 mg) is recommended if the patient has a BMI of more than 26 kg/m^2 or weighs more than 70 kg.[1]

The use of oral ECPs can be associated with headache, nausea and pelvic pain in a small number of users. Although most users will menstruate within seven days of the expected time, the next period can be delayed by more than seven days in about 10% of LNG ECP and 20% of UPA ECP users.

Contraceptive choices

You let Josie know that should she ever need the oral ECP again it is available from the pharmacy without prescription. In some circumstances a prescription can be useful where there is a concern the pharmacy will limit supply to younger women. However, her visit is opportune as it is important to discuss her ongoing contraception needs. She does not want an IUD and you inform her that the contraceptive implant is the most effective method, but Josie thinks the combined oral contraceptive (COC) pill is a good idea as she would like to be able to skip periods.

You explain that if Josie chooses the LNG ECP she could start the COC (or implant if she had chosen it) straight away. However, were she to choose the UPA ECP, initiation of the COC must be delayed for five days because any hormonal contraception taken during this time will decrease the efficacy of the UPA ECP. For either ECP, Josie would need to use condoms until the COC is started and she has taken seven active pills in a row. The alternative is to wait until the first day of her next period to start the COC but it is usually preferable to start ongoing contraception as soon as possible to reduce the chance of an unintended pregnancy later in that cycle.

Outcome

Josie decides to take the LNG ECP and to start a COC straight away. You explain the importance of a follow-up pregnancy test four weeks later. Although pregnancy testing is not required for many ECP users it is necessary, as in Josie's case, when hormonal contraception is started with an oral ECP (or in the case of UPA, five days later). This is because hormone-related bleeding might be misinterpreted as menstruation. For those who do not start a hormonal method of contraception, a follow-up pregnancy test would be advised if the next period is delayed by more than seven days or is lighter than expected. A follow-up pregnancy test is especially important in a woman who has used an oral ECP multiple times during her menstrual cycle or if she reports abdominal pain atypical of normal dysmenorrhoea.

You also advise Josie that testing for sexually transmissible infections is recommended in all sexually active young people.

As there has been a lot of information for Josie to take in on one visit you provide her with factsheets on emergency contraception and the COC. You ask her to contact you should she have problems and agree that her return visit for a pregnancy test and chlamydia test in four weeks will provide another useful opportunity to answer any questions she may have. MT

Reference

1. Faculty of Sexual & Reproductive Healthcare (FSRH). FSRH guideline: emergency contraception. London, UK: FSRH: 2017. Available online at: www.fsrh.org/documents/ceu-clinical-guidance-emergency-contraception-march-2017 (accessed June 2019).

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