Clinical case review

A young girl in need of contraception: the legal position of the GP

Commentary by **CHRISTINE READ** MB BS, ThA, FAChSHM, GradCertPH

Generally, parental or guardian consent is not required when a minor is considered by the medical practitioner to be mature enough to give informed consent.

Case scenario

Shona, an Aboriginal girl who had just turned 13 years old, was brought in to see me by her aunt who said that the family had decided that Shona needed reliable contraception. Shona was already sexually active (consensually) and had recently run away from home for a few days with her 16-year-old boyfriend, who was in and out of remand centres. Shona was reluctant to talk about the issue, but giggled at questions about condoms and said that she would not use them. She was similarly rejecting of the aunt's suggestion of injectable or implanted progestogen. She appeared to me to be unrealistic about contraceptive use and to behave and understand consequences only at about the level you would expect from an average 8-year-old. Shona's mother was unable to be contacted, and her father had vanished years before.

What is the legal position of the GP in such a situation? Can the parent or other guardian make the decision in the best interests of the child?

Case outcome

Thankfully, we finally managed to contact the mother, who talked Shona through the procedure on the phone while I was inserting the etonogestrel implant.

Dr Read is the Medical Director at Family Planning NSW, Sydney, NSW.

Commentary

Consultations that involve young patients, especially those that deal with sexual activity, need to cover some specific legal issues including confidentiality, consent and child protection. In addition, cases that involve patients from cultures different from that of the mainstream health service require attention to culturally appropriate behaviours.

The case of Shona illustrates all of these issues and the challenges of dealing appropriately with the various components.

As doctors, our primary concern is, of course, the patient, but we must also act within the law. Many GPs express concern about their legal obligations in providing contraception to persons younger than the legal age for consenting sexual intercourse of 16 years, and also their responsibility as mandatory reporters of sexual activity under child protection legislation.

Aboriginal culture

There is an enormous diversity of Aboriginal culture, but in at least some Aboriginal communities it is an aunt's cultural responsibility to provide information and education to her nieces regarding sexual and reproductive health issues. In addition, Aboriginal children can be raised by aunts, grandparents or other family members through formal arrangements when there have been child protection issues, or through informal arrangements that are established by and within families and communities.

For the medical practitioner, it is important not to make any assumptions about which of these factors might be involved in an individual case, but instead to talk to the patient and the relatives to evaluate the situation.

Confidentiality

Shona was brought in to see the doctor by her aunt but confidentiality is still a crucial aspect of the consultation. An explanation of the confidentiality applicable in this case is important both in setting the parameters for the consultation from the legal perspective and also for clearly identifying that the young person is the client or patient and that she has a right to have an opportunity to speak frankly with the practitioner and make choices in her own health care.

With regard to Shona's cultural heritage, there is a potential for miscommunication when there are significant cultural differences between the practitioner and patient. Health practitioners who are Aboriginal (including Aboriginal Health Workers) can, if they are available, often assist with cross-cultural communication issues. However, it is always necessary to check with patients first that they are happy for this involvement. A further consideration is the gender of the practitioner; in a consultation like this case, a female GP may be preferable.

What the law says

In general, young people have the same right to confidentiality in clinical care as older people. In most states and territories of Australia, however, the law overrides

these rights in the following circumstances:

- where there is thought to be a 'risk of harm' – as in sexual, physical or emotional abuse or neglect ('child protection')
- where files have been subpoenaed by the courts
- when the sharing with other health care practitioners of the information contained in the file is necessary to provide the best health care to the individual.

Consent to treatment

The critical factor in assessing the ability of any person to give consent to a medical treatment is whether he or she understands the nature of the treatment and its consequences. It is this principle that has been used in law to determine whether young people are able to give consent to the use of contraceptives on their own behalf.

What the law says

The law says that a person can consent in his or her own right to medical treatment once he or she reaches the age of 18 years. The law relating to consent under the age of 18 years is not straightforward. Consent may be provided by parents or guardians, but the consent of a parent or guardian is not required when a young person (i.e. a 16- or 17-year-old) or a child (i.e. a person aged under 16 years) is considered mature enough by the medical practitioner to give informed consent.

The consent to medical treatment by a minor is covered in most Australian states and territories by the common law position often referred to as 'Gillick competency'. This relates to a 1986 House of Lords judgment in the UK, *Gillick v. West Norfolk and Wisbech Area Health Authority. [1986] 1 AC 112 (HL)*, which indicated that if a child under the age of 16 years was capable or competent to understand the nature of the treatment proposed, including the nature and effect of any procedures, he or she could consent to the treatment without parental consent.[1,2] A young person meeting these criteria is therefore often referred to as fulfilling 'Gillick competency'. The meeting of the criteria should be clearly documented by the doctor in the patient's notes.

South Australia is the only state in which 'Gillick competency' does not apply. In South Australia, the Consent to Medical Treatment and Palliative Care Act 1995 allows a child under the age of 16 years to consent to medical treatment and procedures only if two doctors examine the child and both agree that the child understands the nature, consequences and risks of the treatment and that the treatment is necessary; both doctors must corroborate this in writing.

When the medical treatment under consideration is what is known as 'special' medical treatment, the consent of the Guardianship Tribunal is required for any person under the age of 18 years. (In NSW, see section 175 of the *Children and Young Persons [Care and Protection] Act.)* 'Special' medical treatments include sterilisation, but not reversible contraception.

In practice

It is important to make efforts to include discussion of the young person's relationship with his or her parents or guardian, because in an ideal situation the parents or guardian should be involved in the child's care. Healthcare practitioners are often able to reassure apprehensive parents or guardians and to give unbiased, credible information about issues of concern. In the event that this is not possible or desirable, it is important to document in the patient's notes the reasons why this young person is competent to make a decision regarding treatment.

When obtaining valid consent from a minor for the administration of contraceptive methods it is critical that communication is clear and that the implications of the treatment are understood. An experienced doctor working in Aboriginal health has commented that, 'Anecdotally and historically there have been cases where clinic workers have administered depot medroxyprogesterone acetate (DMPA) to Aboriginal women without the women understanding what the injections were for. There are cases of women presenting to a clinic because of not having periods or difficulties falling pregnant, only to find out that they have been given regular DMPA injections.' (personal communication).

In the case of a young person like Shona, who is only 13 years old but is clearly sexually active and needing contraception, the following information should be documented in the consultation notes as support for the valid consent of this young person:[3]

- this young woman, although under the age of 16 years, understands the contraceptive advice, including the mechanism of action and any risks involved
- if she has not already informed her parents that she is seeking contraception, she cannot be persuaded to do so herself or to allow the medical practitioner to do so
- she is very likely to have sexual intercourse whether or not she has contraception
- her physical or mental health, or both, is likely to suffer unless she receives contraceptive advice or treatment
- her best interests require the medical practitioner to give her contraceptive advice or treatment, or both, without parental consent.

Shona, however, seems immature for her age and unrealistic about contraception, and whether she could be considered to understand the contraceptive advice is debatable. Difficult cases such as Shona's require examination on a case-by-case basis. The intent is always to obtain the best outcome for both the patient and the parent or guardian and the agreement of both to the proposed treatment. As mentioned previously, a parent or guardian can generally consent to treatment for his or her child unless that treatment is a special medical treatment, which requires the consent of the Guardianship Tribunal. Special medical treatment does not include reversible contraception but does include sterilisation.

Child protection

Undertaking a general psychosocial assessment of young people can provide a useful baseline to establish rapport and assess competency and risk of harm/child protection issues. An example of such an assessment is the HEADSS assessment, which provides information about the young person's functioning in the key areas of his or her life of home (H), education, employment, eating and exercise (E), activities and peer relationships (A), drug, cigarette and alcohol use, (D), sexuality (S) and suicide, depression and mood (S).[4]

What the law says

The child protection laws are different in each state and territory of Australia and healthcare workers should familiarise themselves with the local legislative requirements. Of note, the Northern Territory has recently enacted new legislation that has made reporting of all sexual activity in under 16-year-olds mandatory; healthcare workers are now lobbying to change these stringent laws to make them more workable in practice.

In general, doctors and other health professionals are considered mandatory reporters with regard to child protection laws.

In practice

Having to report regarding possible breaches of the child protection laws means that doctors and other health professionals must make a decision about whether the young person is 'at risk of harm' and, in terms of contraceptive prescription, whether she is involved in a sexual relationship that could be abusive or harmful. Practitioners should consider specifically whether the sexual relationship involves family members and is consensual or nonconsensual, and whether there is a significant age gap or inappropriate power differential between the participants. It is important to document these issues in the consultation notes, particularly whether it is a consensual relationship and the age of the partner.

A discussion of sexually transmissible infection risk and safe sex issues should also form part of the consultation. All young, sexually active patients should be encouraged to undergo testing for *Chlamydia*, but practitioners should be aware that a positive test generates a notification to the Public Health Unit, and the unit may make contact regarding mandatory reporting as well as regarding test results.

Child protection laws also require the practitioner to notify if there is a risk of physical or emotional abuse, or neglect.

Summary

While the law is clear regarding consent to medical treatment in a person over the age of 18 years, the situation relating to such consent in a person under the age of 18 is not as straightforward. Although consent may be provided by parents or guardians of a young person (aged 16 or 17 years) or a child (aged under 16 years), parental or guardian consent is not required in cases where the minor is considered by the medical practitioner to be mature enough to give informed consent. The common law position often referred to as 'Gillick competency' considers that if a child under the age of 16 years is capable or competent to understand the nature of the treatment proposed, including the nature and effect of any procedures, he or she can consent to the treatment without parental consent. If the young person or child is not considered mature enough, the parent or guardian can generally consent to treatment for the child, in the best interests of the child, unless that treatment is a 'special' medical treatment (such as sterilisation), in which case the consent of the Guardianship Tribunal is required. It can be difficult to confidently determine maturity in young adolescents, and practitioners should attempt to have the consent of both the child and the parent or guardian when dealing with young adolescents.

There is a potential for miscommunication when cases involve patients from cultures different from that of the mainstream health service. Involvement of health workers of the relevant culture can assist with cross-cultural communication and behavioural issues. MT

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Further reading

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COMPETING INTERESTS: Dr Read has provided expert opinion for Bayer, Schering Plough and Wyeth as part of her employment with Family Planning NSW. She has received support for conference attendance from Bayer and Schering Plough and is an investigator for a Schering Plough contraceptive study.