To report or not to report? That is the question

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Introduction

In New Zealand general practices, we come across adolescents who are sexually active. It is quite clear in New Zealand law that e*veryone* (including minors) who has sexual connection with a young person below the age of 16 years is potentially liable for prosecution and imprisonment.[1,2] In the UK, there is mandatory reporting of all sexually active children aged 13 years or less.[3,4] Many people feel that every instance of under-age intercourse should be reported to the police; however, mandatory reporting can be counter-productive.[3] It reduces attendance of adolescents at sexual health and family planning services, so children who may be at most risk may not present and thus not be identified.[3,5] Mandatory reporting can criminalise essentially good people involved in consensual relationship, the harm of this being not insignificant to the individuals, their families, and the wider community, and could potentially overwhelm police and social services resources.[6]

One pragmatic approach for dealing with cases of sexually active minors is to assess each case individually for signs of abuse, and consider the context of the child's overall life (eg are there signs of other risk-taking behaviour, intellectual impairment or vulnerability?). This approach makes it an *ethical*, not a *legal* decision to report sexually active adolescents to authorities.

If we accept that this is an ethical rather than a legal decision, we then need to know how ethics can be useful in deciding whether this was an abusive relationship, and if it is in the adolescent's best interest to report this to the police, because as this case shows, the two decisions may not, ethically speaking, be one and the same.

The case

'Angel' presented at a general practice (all details have been changed to protect her identity, but in a way that preserves the ethical issues). She was 15 years and 10 months old at the time. She was from a low socioeconomic background, relatively isolated from resources, and had few cultural or family roots to support her.

She presented with a vaginal discharge and was worried she had a sexually transmitted infection (STI). She was in a relationship with 'Jack' who was 22 years old. He had picked her up from a cafe when she had been truanting a month previously. Recently, Jack had told her he was also sleeping with a woman who was HIV positive and he had not used condoms with either her or Angel. She seemed ambivalent as to whether she really wanted to sleep with him, saying sometimes she 'couldn't be bothered to stop him', especially when they had been drinking. She seemed to understand the consultation and what the discharge could mean. She stated she was feeling very low and had been cutting herself. Her swab results came back positive for an STI. Angel did not feel comfortable telling Jack the results and so she asked the general practitioner (GP) to do this. A phone call, uncomfortable for both the GP and Jack (who was unknown to the GP), ensued. He was incandescent with rage: 'Who is it? I bet it was Angel! The f****** slag! I'm going to f****** get her!'. While acknowledging Jack also may have been fearful and with his own needs, the circumstances of the call made it very difficult for the GP to be able to help him.

A colleague who specialises in child protection and sexual abuse was consulted and she advised that this situation should be reported to the police. The consulting GP told Angel she had worries about her relationship and she would have to tell the police about it. Angel said she 'didn't mind' because she 'didn't like him'. With Angel's and Jack's responses, the GP felt more justified in calling the police and reporting a case of possible unlawful sexual connection with a minor. The police 'had a word' with Jack, but did not feel that any grounds existed for taking things further.

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Angel came back to see the GP only a week later. She walked in off the streets crying and in a bedraggled state, without shoes and in torn clothes. There were large bruises on her neck. She said she had been smoking with some friends yesterday then 'woke up' at the bottom of a hill this morning. She had then walked straight to the practice. Her underwear was stained and full of sand. She nodded when asked if she had been raped.

The police were called and she was accompanied by two detectives to a major city for forensic examination. No charges were ever laid. She did not present to the practice again. There were reports in the community of her wild behaviour, until she moved overseas and died in a motorbike accident.

What is ethically at stake here?

We argue that the ethical issues centre on two key questions:

1. Is the relationship between Angel and Jack abusive, and;
2. Should this be reported to the police?

A third question concerns the process of decision-making: how can ethics helpfully address these questions?

Is this abuse?

Children have a right to be and feel safe and so we have a responsibility as GPs to ensure that we protect children from abuse, and be law-abiding citizens. If we assume that this is a question of ethics and not of law, then we need to be very clear how ethics helps us decide if the child has, in fact, been abused in the first place.

Abuse can be defined ethically as a violation of autonomy and dignity.[7] An autonomous person shapes and directs his or her own life, based on their own values, to bring about their own choices and plans.[8] Being autonomous expresses aspects of being human that we value highly, such as decisions that foster our particular character traits and interests that make us unique individuals.[9] Mill, as discussed by Gray, suggests that the only time that one person may have power over another is to prevent harm to that person or others.[10]

Understanding autonomy is central to understanding personhood. Simply put, autonomy is the freedom of thought, action and will of an individual. One means by which autonomy is actualised and operationalised is via the process of informed consent and in order to be fully autonomous there must be no coercion, full information must be provided and the person making the decision must be competent.[9] Impairment in one or all of these areas would lead to diminished autonomy with a potential for loss of one's uniqueness, identity and personhood, which can be thought of as human dignity. A violation of dignity is a violation of humanity.[11] A violation of one's humanity is abuse.

Because Angel was legally a child, one could argue that if she were not competent then, *ipso facto*, the action of Jack would be abuse as she could not give true consent to sexual intercourse. The case would require no more thought. However, autonomy and the competency to consent is decision- and situation-specific, and the more complex the situation or more serious the consequences of the decision, the greater the cognitive ability needed to satisfy competence.[12] Studies have shown that in general, most 14-year-olds are as competent as adults.[11] Angel had demonstrated her competency in some matters; for example, she understood the nature of a vaginal discharge, and also understood how and where to get help for this. On this basis, perhaps she was competent?

One of the reasons why many advocate for reporting all under age sexual activity is that the issues of competency and coercion become complicated when applied to a minor. Teenagers' consent can fall into a 'grey area that lies somewhere between mutually desired, pleasurable sex and rape'.[3] Fear, peer pressure, desire for male attention and being programmed to do what older people expect of them all may play a part, as well as not having the skills to get out of a situation that escalates, or when intimidation occurs without overt force.[3] So, while a minor may agree (or not disagree) to sexual intercourse, it is more difficult to know if their autonomy was violated

by these subtle yet powerfully coercive factors. In Angel's case, her consent appears at best ambiguous and ambivalent, and submission to sex alone does not imply consent.[1,7]

What we consider ourselves free to do also depends on our perceived obligations, which can restrain (correctly or not) our own self-perceptions of the extent of our own autonomy.[7] If Angel felt an obligation to sleep with Jack, for whatever reason, she may have (correctly or not) relinquished her capacity to choose in this respect. Obligation, combined with inability to negotiate or stop the situation (due, for example, to low mood, alcohol and characteristics of her age), and inopportunity to get away (as she had no car, no money and no family to call on to protect her), may lead us to suspect that she actually had very little autonomy in this situation.

Suspicions are not ethically equivalent to proof. Many ethical nuances of competency would need to be assessed and explored in order to reach an ethically sound conclusion, and this could be very problematic in the time-poor world of a GP. Here, we believe the issue is actually relatively simple and clear cut, and is not based on competency at all; Angel was not able to act competently and autonomously in giving consent for sex as she was not fully informed. Jack failed to tell her initially that he was placing her life in danger through his simultaneous sexual relationship with a woman who was known to be carrying HIV. Through this significant lack of information, her competency was impaired, her ability to give informed consent stymied and her autonomy fettered; her humanity was violated and a situation of abuse and not a partnership existed. Hence, the answer to the first question is yes, the relationship was abusive, and in this case, it is based clearly on a failure to meet one of the necessary prerequisites for the exercise of one's competency and hence autonomy, namely a failure in being fully informed. An application of the other principles of beneficence, non-maleficence and justice could easily be structured to further support this course of action. However, once one principle has crossed this all-or-nothing threshold, further elaboration using the other principles is redundant.

Should this have been reported to the police?

It may appear that once it is established that a relationship involving a minor is abusive, then it is a *sine qua non* that the police should be involved. However, the tragic outcome of this case suggests that perhaps this was not so. With the benefit of hindsight, was reporting this situation twice to the police the best ethical decision? When faced with the initial encounter there was no crystal ball. While a principles framework, and autonomy in particular, served very well in deciding if abuse did indeed occur, it was less useful in anticipating possible outcomes and understanding what means were needed to arrive at the desired end of a young adult living a good human life, not one enmeshed in violence, abuse and poverty. Even though Angel had an extremely different life to most GPs, empathy with her plight was important. It directed the GP towards supporting her, not in a paternalistic way, but in one which attempted to honour her unique personhood.

Within an empathic response, action can be guided by thinking, 'What would a virtuous person do here?'.[13] Pellegrino lists virtues specific to the medical practitioner, including benevolence, trust, courage, compassion and prudence.[14] Prudence is essential to any clinical decision and is the practical wisdom needed to weigh up alternatives.[15,16] Involving the police was motivated by all these virtues, yet the outcome was tragic. So how can GPs live with outcomes similar to this as most of us will encounter tragedy in one form or another in our practice? The answer lives in another virtue. Pellegrino upholds intellectual honesty as a virtue, one which leads to humility, which demands that we admit when we do not know something.[14] Being 'unimpressed with oneself' allows one to learn, and patients to be safe.[17] Humility releases us from the ego, by realising that even the most virtuous person can never be certain they will not make a mistake, and that even the most powerful person has things beyond their control.[18] If the decision is made from virtuous motives then, even if there are disastrous consequences (as in this case), we would argue, as others do,[19] the decision is still morally correct.

Virtues are qualities acquired through life experience and so one's capacity for virtuous action can develop with time.[20] What was learnt by the GP through this case was that even knowing the terrible harms that this action caused, after weighing up the ethical evidence, they would still inform the police because at the time this decision was made, the only other option was to do nothing, which would have colluded with her abuse: '…an uncritical tolerance for the status quo'.[21] In hindsight, the GP believes the virtue of courage was needed to follow through and challenge the response from the police, but this then begs the question, 'Where do doctors' responsibilities end?'. The outcome may well have been the same.

Conclusion

By setting a course for a desired destination (to protect the child from harm), an application of the principle of autonomy allowed a clear decision to be made that this was an abusive relationship; it was not helpful, however, in deciding the means to reach the desired goal of helping Angel. Virtues illuminated a path to attempt to act ethically in an uncertain world, because the one certain influence anyone has is on one's own character. And at the end of the day, GPs have to live with the decisions they make. Knowing what this is based on makes this easier to bear. We have to accept we cannot *force* someone else's life to be better just because we desperately want it so; we can only *try* to enable flourishing.

COMPETING INTERESTS
The authors declare no competing interests.

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