

Impersonating another patient in order to procure an abortion

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Clinical scenario

Susan, an 18-year-old, presents to you in a community setting requesting a termination of pregnancy (TOP). You see from her notes that she had a TOP 6 months earlier and, in the course of the history taking, you raise this with her. She confesses that in fact she didn't have this TOP but her sister, Nicola, who was 15 years old at the time, had it in her name. Nicola, believing that her parents would have been informed had she presented as herself, had pretended to be Susan. The two sisters had decided together that this was the best thing to do. Susan tells you that Nicola would verify the story. How would you proceed and what issues need to be addressed?

The panel

A panel of three individuals—two health professionals and a barrister (detailed in Box 1)—were invited to give their views on how this case should be managed.

Box 1: Invited discussants for the clinical scenario

- General practitioner
- Consultant gynaecologist
- Barrister

General practitioner

Never were there such devoted sisters! This is a tricky situation, and I would want to seek the advice of my defence union. There are a few issues to deal with, not least the immediate problem of the elder sister's current pregnancy. Some units do have policies that limit the number of terminations an individual can have. I would ask Susan if she could bring Nicola in to a double appointment to discuss and clarify the situation, and hopefully she would be able to confirm her sister's story. I would be able to talk to them separately if they wished. They need to be made aware of the seriousness of the situation, which could have had medical consequences, as well as being fraud. I would try to get this over in a non-judgmental way.

I would explain to them what confidentiality meant, and advise them that their parents wouldn't have been informed if it was thought that Nicola was competent to understand the situation at the time, although she would have been encouraged to inform her parents. I would tell them that we need to let the gynaecology unit know what has happened so that records can be amended, and our records would also need to reflect the true situation. There is also the question as to whether her parents need to be informed about what has happened. Susan is 18 years old and there is her own confidentiality to protect. It would be difficult to tell the parents about their younger daughter's fraudulent act without involving the elder sister. I think if Nicola seems to grasp the seriousness of the situation then I would probably not involve the parents, but I would want to clarify matters

J Fam Plann Reprod Health Care 2007; **33**(3): 213–214

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in my discussion with my defence union.

I would want to speak to Nicola about her pregnancy and find out if the intercourse had been consensual or if there was any question of it being inappropriate. She needs to be aware that sex with a girl aged under 16 years is illegal. If she is in a continuing relationship, I would want to make sure that she was using contraception and condoms. I would give her information on sexually transmitted infections (STIs). This would also be discussed with Susan, before referring her for a TOP, if appropriate.

In general, it might be worth reviewing the practice leaflet and website, and making sure the information on confidentiality was clear, especially to teenagers. A poster in the waiting room could also be helpful. I would talk to my partners about the case; it might be worth having a special teenage clinic if it was thought that there was sufficient demand.

Consultant gynaecologist

From a legal aspect, the first thing to do is to tell Susan (so that she can tell Nicola) that all consultations, regardless of the patient's age, are confidential. Nicola was presumably sufficiently convincing that the people who saw her did not question her age and believed her to be 18 years old. As such, she would appear to have been sufficiently mature to be considered retrospectively as 'Gillick competent'. In Scotland, where I practise, under Scots law a person younger than 16 years can be deemed to have the capacity to consent to treatment or procedure with the proviso that he or she is capable of understanding the nature and consequences of the proposed treatment or procedure.¹ Nevertheless, it would have been preferable for Nicola to have spoken to her parents prior to the TOP.

Nicola was underage and it is important to establish the age of the male and whether or not it was a consenting relationship. If he was 16 years or over then it could be deemed as 'assault'; if it was a consenting relationship, then his age becomes less of an issue. However, if there is a substantial age difference then that does raise the issue of 'child grooming', in which case it may be necessary to pursue the matter in order to protect other young people who may be potential 'targets' and who may not be physically or psychologically as mature as Nicola.

From a medical aspect it is important to encourage Nicola to return for a discussion about lifestyle and sexual health issues. It must be established if she remains sexually active and, if so, what contraception she is using. Ideally she should be using a long-acting reversible contraceptive (such as Depo-Provera[®], Implanon[®] or a Mirena[®] intrauterine system) as these methods have the lowest failure rates. Furthermore, it would be preferable if Nicola was encouraging her male partner to use condoms to protect from STIs. It would be important to determine tactfully how many partners she has had as the greater the number of partners, the greater the chance of acquiring an STI, which in turn could compromise her future fertility. Hence, it would be an opportune moment for important sexual health promotion.

Barrister

Initially it would be helpful to verify the story. This would best be done by speaking to Nicola, before embarking upon

what may be a second TOP for Susan. If it is not possible to speak to Nicola, then additional enquiries should be made from the notes and from questions to Susan to establish whether this account is true.

If the story is believed to be false, Susan should be counselled about the undesirability of undergoing two terminations in 6 months. After appropriate advice and counselling, Susan can be invited to consider her options: caring for the child, adoption or termination.

If the story is believed to be true, a number of issues arise, in addition to the normal consultation that would be required with an 18-year-old seeking a termination.

First, a warning should be given to both girls about the dangers of impersonating other patients where medical procedures are to take place.

Next, assuming that sexual intercourse caused Nicola's pregnancy, a crime has been committed. Having sexual intercourse with a girl aged under 16 years is an offence. How serious that offence is depends upon who has committed it. There are potentially serious child protection issues, particularly if the offender is a mature adult or in a position of trust.

Exploring these issues would best be done with Nicola, although it may be possible to obtain some preliminary information from Susan. It is likely to be necessary to report the situation concerning Nicola to a third-party agency. There is no issue concerning Susan that needs to be reported, either to any agency or to her parents.

There is currently no relationship between the medical practitioner and Nicola, and making a report does not therefore present any issue of confidentiality between them. If the practitioner does speak to Nicola, it should only be on the basis of an anticipated disclosure of this information, and that should be made clear. Although reporting these revelations may undermine the trust between the practitioner and Susan, matters of child welfare must always take priority.

Ultimately, issues of child protection are for social services, and issues of criminal offences are for the police. In all matters concerning children, involvement with the criminal justice system should be the very last resort. The most appropriate agency to report this situation to is the local social services and not the local police.

Summary

There are a number of interesting points raised by our panel. The clinicians acknowledge their duty of care to

Nicola despite the fact that she is not the patient in that consultation. Does this obligation differ if she is not his patient? They are concerned about her ongoing contraceptive needs and STI risk but they have a moral concern surrounding the relationship between Nicola and her partner as she is below the age of consent. Is it permissible for the clinician to take a decision that if the sex was consensual with a young man of a similar age then this can remain unreported? How serious is the issue of impersonating another person in order to procure such a medical procedure?

The panel members are in agreement that they would invite Nicola in to discuss these issues. It would appear that the clinician should inform Susan of the implications of what she has said before inviting her in, and that in verifying this story Nicola's partner may be reported to an agency such as social services.

It is at this point that the clinician's duty of care becomes less clear. Is it appropriate simply to ask Susan to tell her sister to go to a family planning clinic? Should Susan be asked to invite her sister to come and see you to discuss the issues? What do you do if she doesn't come? Do you go to her house, thereby potentially involving her parents whom you know she does not wish to inform and indeed were the very reason she impersonated her sister in the first instance?

Some of these questions were posed to a defence union advisor. He felt that – as we have Nicola 'in our contemplation' – we have a duty of care to her and to help prevent any foreseeable harm. One has to form a view of what would be in Nicola's best interest and this is likely to include the medical follow-up detailed above and an attempt to gain further information as to whether her relationship was appropriate. With regard to the latter, it is for the clinician to judge whether the social services need to be involved. Should Nicola fail to come to see you, however, how far does one go to pursue this? Whatever one chooses to do there is the potential for criticism, but ultimately one has to be able to justify that any action one takes is an attempt to ensure that Nicola comes to no harm.

Acknowledgements

The author would like to thank the panel members for their input. A listing of the individual panel members who have contributed to the Clinical Conundrum section of the Journal is published annually.

Reference

- 1 Age of Legal Capacity (Scotland) Act 1991 s2(4).

NEWS ROUNDUP

Role of specialist PHSE teachers

The National Healthy Schools Programme (NHSP), jointly funded by the Department of Health and the Department of Education and Skills, promotes healthy eating, physical activity, sex and relationships, drugs and alcohol, emotional health and well-being, and personal, social and health education. The NHSP supports teaching by specialist PHSE teachers as opposed to form tutors to improve teaching quality. Colin Noble, Acting Head of NHSP said "Schools working with the NHSP have been able to develop successful links with support services staffed by general practitioners, practice and school nurses, health visitors and other health and youth workers who have had a positive impact on pupils". The provision of quality PHSE can reduce levels of sexually transmitted infections and unintended teenage pregnancy.

Source: <http://www.hda.nhs.uk>

Timing of postmenopausal hormone therapy and risk of cardiovascular disease

Secondary analysis of the Women's Health Initiative (WHI) study suggests that the timing of initiation of hormone therapy may influence its effect on cardiovascular disease.¹ The aim was to explore whether the effects of hormone therapy on risk of cardiovascular disease vary by age or years since menopause began. The analysis shows that women who initiate hormone therapy closer to menopause tended to have reduced coronary heart disease (CHD) risk compared with the increase in CHD risk among women more distant from menopause, but this trend did not meet the criterion for statistical significance. A similar non-significant trend was observed for total mortality but the risk of stroke was elevated regardless of years since menopause. These data should be considered with regard to the short-term treatment of menopausal symptoms.

Reference

- 1 Rossouw JE, Prentice RL, Manson JE, Wu L, Barad D, Barnabei VM, *et al.* Postmenopausal hormone therapy and risk of cardiovascular disease by age and years since menopause. *JAMA* 2007; **297**: 1465–1477.

Brook trustees appoint a new Chair

Evelyn Asante-Mensah has been appointed Chair of the Board of Trustees of Brook, the leading sexual health charity for young people, from July 2007.

Evelyn Asante-Mensah said: "Britain's teenage pregnancy rates, although gradually declining, are still higher than anywhere else in Europe, and sexually transmitted infections are soaring. Sexual health must be a priority for everyone working with young people."

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