Impersonating another patient in order to procure an abortion

Brigid Molloy

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 have done this then her parents must also be involved. The question is should they be told the extent of the situation or just what happened?

In my discussion with my defence union...

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.

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
counselling 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).

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.

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 test 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

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.”

For further information contact Catherine Evans, E-mail: catherine@brookcentres.org.uk. Tel: 020 7284 6047.

Reported by Henrietta Hughes, MRCGP, DFFP
General Practitioner, London, UK

Source: http://www.bda.org.uk
Impersonating another patient in order to procure an abortion

Brigid Molloy

*J Fam Plann Reprod Health Care* 2007 33: 213-214
doi: 10.1783/147118907781005128

Updated information and services can be found at:
http://jfprhc.bmj.com/content/33/3/213.citation

These include:

Email alerting service
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Notes