London Journal of Primary Care

ISSN: 1757-1472 (Print) 1757-1480 (Online) Journal homepage: http://tandfonline.com/loi/tlpc20

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To cite this article: Andrew Papanikitas (2009) General practice, clinical intention and the Sexual Offences Act 2003, London Journal of Primary Care, 2:2, 146-150, DOI: 10.1080/17571472.2009.11493270

To link to this article: http://dx.doi.org/10.1080/17571472.2009.11493270

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Published online: 07 Oct 2015.

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London Journal of Primary Care 2009;2:146–50 © 2009 Royal College of General Practitioners

Ethics

General practice, clinical intention and the Sexual Offences Act 2003

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Key messages

GPs need to be able to justify difficult decisions in retrospect. Advance discussion of the ethical and legal reasoning behind difficult decisions may be useful in both making the correct decision and justifying it clearly in retrospect. This article applies this idea particularly in terms of meeting the criteria for providing sexual health services to children under the 2003 Sexual Offences Act. Health professionals should be aware of the double effect of providing contraception or sexual advice to children, and be aware of potentially flouting the law. Thus far, however, health professionals should feel reassured that the Sexual Offences Act 2003 appears to be sensibly applied in the UK.

Why this matters to me

This is an issue which I have come across in practice as a trainee and as a qualified GP. I have perhaps given more thought to this in recent months as I am currently undertaking research towards an MPhil/PhD at the Centre for Biomedicine and Society (King's College London), investigating explicit and implicit decision-making strategies which are used by UK general practitioners when a conflict of duties arises.

ABSTRACT

General practitioners must be capable of regularly taking 'ultimate' responsibility for difficult decisions in situations of clinical complexity and uncertainty. The Sexual Offences Act 2003 criminalises all sexual activity with a child under the age of 16. However, those who act with the purpose of protecting a child from a sexually transmitted infection, protecting the physical safety of a child, preventing the child from becoming pregnant or promoting the child's emotional well-being by the giving of advice will not commit an offence. Medico-legal academic writers have compared the legal separation of intention and foreseeability with the special defence of double-effect used in the palliative care context. This paper seeks to draw upon legal principles in constructing an ethical framework for analysis of this issue. It is hoped that this case study will stimulate further discussion, clarify the moral reasoning underpinning the existing guidelines for GPs and how the doctrine or principle of double effect can be used outside the palliative medicine context.

Keywords: children, double effect, ethics, general practice, intention, sexual offences

A 'for example' requiring more information

During a 10 minute appointment for a sore throat, a 13 (nearly 14) year old girl divulges to her GP that she has just met her first 'proper' boyfriend. She asks for advice about contraceptives. When asked, she states that her parent are unaware of her relationship and she plans to tell them when she is older and can't be 'grounded'.

Background

The Sexual Offences Act 2003 (since May 2004) criminalises all sexual activity with a child under the age of 16. Crown Prosecution Service and Home Office guidance suggests that prosecution is unlikely if parties are close in age and activity is consensual. Sexual activity below the age of 13 years is always an offence, 14–16 year olds have limited capacity to consent, and 16–18 year olds have presumed capacity to consent.[1] As with vulnerable adults, there are specific legal protections in place concerning abuse of trust and incest.[2]

Under the act, 'Those who act with the purpose of protecting a child from a sexually transmitted infection, protecting the physical safety of a child, preventing the child from becoming pregnant or promoting the child's emotional well-being by the giving of advice will not commit an offence'.[3]

The guidance on consent and public interest stems from Lord Fraser's guidelines in the House of Lords Judgement regarding Gillick:[4]

- the young person understands the advice given
- the young person cannot be persuaded to inform parents or allow the doctor to do so
- it is likely that the young person will continue to have sexual intercourse with or without the contraception
- the young person's mental or physical health may suffer as a result of withholding contraceptive advice or treatment
- it is in the best interest of the young person for the clinician to provide contraceptive advice, treatment or both without parental consent.

Providing the guidelines are followed, GPs can expect not to be prosecuted as an accessory under the Sexual Offences Act 2003. It may seem sensationalist to suggest that deviation from the guidelines, by implication, leaves a GP liable as accessory to a crime. Certainly I am not aware of any GP who has been successfully prosecuted. However it is disturbing to note the findings of a recent study by Dunphy *et al*[5] which was reported in the *International Journal of STD & AIDS*. A true/false questionnaire was developed comprising statements concerning sexual activity in young people. It was sent to a sample of family planning staff, genitourinary (GU) medicine nurses and doctors in 102 family planning and 261 GU-medicine clinics throughout England and Wales. A total of 168 completed questionnaires were returned. The range of correct responses for the whole group was between two and ten out of ten, with a median of six. Dunphy and colleagues identified some misunderstanding concerning the term 'Fraser' competence and the legal basis on which contraception can be provided to under 16 year olds, as well as some lack of awareness concerning present advice on child protection. In free text responses, many people volunteered educational needs.

In 2005 some Child Protection Committees issued guidance imposing a requirement to report all sexually active people under the age of 13 (and in some cases under the age of 16) to the police. A number of health bodies, including the BMA, challenged this guidance arguing that whilst reporting to social services or the police should always be considered where the individual is very young, the obligation of health professionals is to act in the best interests of the patient and this requires flexibility.[6]

The Gillick test for autonomy has been extensively commented on in the law and ethics literature. However, the intention of the GP (or other clinician) and the reasoning behind exculpation from liability is often 'glossed-over'. Certainly consent to the crime by its victim *per se* does not constitute a defence for the perpetrator of the crime, even if the action is to end distress[7], or to give pleasure.[8] In the two cases referred to 'what is being consented to' is as important as the consent itself. One of the dissenting judges in the House of Lords case, Lord Brandon, based his argument almost exclusively on the criminal law, and considered the issue of consent largely irrelevant.[9]

The rationale behind the Fraser Guidelines[10] appears to be that:

- a clinician who provides a girl [or boy] under the age of 16 (or the older partner) advice or prescriptions with the intention of providing sexual intercourse, 'Is an accessory before the fact to an offence'[11]
- it is in the best interests for the victim of a sexual offence to be protected against the consequences of the offence, which may occur with or without the advice of prescription
- the prescribing clinician does not intend the 'promotion or encouragement' of underage sex, and may prescribe (for example) contraceptives despite being 'firmly against it'.

Intention and foresight: separate in this case?

A legal and ethical distinction between intention and foresight, as usually embodied in the principle, rule or doctrine of double effect, has been widely applied by the medical profession. As a recent handbook of ethics puts it, 'It is difficult to imagine clinical practice without it, particularly at the end of life'.[12]

Put simply, double effect provides a framework that permits tolerance of the lesser of two evils in the following circumstances:

1 the nature of the act itself is itself good, or at least morally neutral
2 the agent intends the good effect only
3 the agent does not intend the bad effect either as a means to the good or as an end in itself
4 the good effect outweighs the bad effect in circumstances sufficiently grave to justify risking or causing the bad effect and the agent exercises due diligence to avoid or minimise the harm.[13]

There is no clear statutory definition of intention in English law. For example, a jury are not entitled to find the necessary intention for murder unless they feel sure that death or serious bodily harm was a virtual certainty, as a result of the defendant's actions and the defendant appreciated that this was the case.[14]

The leading legal case which lawyers refer to concerns a man who threw his infant child against a hard surface, and then argued that he did not intend serious harm.[15] The logical conclusion is that everyone (including doctors) may be liable for the virtually certain consequences of their actions (if these give rise to a legal offence). By contrast Section 8 of the Criminal Justice act 1967 provides that 'a jury is not bound to infer that a person intended or foresaw a result of his actions by reason only of its being a natural and probable consequence of those actions'.

Though doctors are 'not entitled to special consideration,'[16] context is also relevant. Can the wilful intention to harm be placed in the same category as that of a clinician who has a professional, moral (or legal) duty to relieve suffering and who does so with the knowledge that this may result in harm?

While discussing palliative treatments[17] and terminal sedation[18] respectively, two legal commentaries on the Doctrine of Double Effect in law cite Gillick (1986) as evidence that doctors are not presumed to intend all the consequences of their actions. They ask whether doctors use a deliberately narrow legal definition of intention, and whether the principle of double-effect in law is evidence of this.[14]

Another way of asking the same question might be: Can a double-effect framework be applied in the context of The Fraser/Sexual Offences Act 2003 Guidelines?

The Fraser/Sexual Offences Act 2003 Guidelines could be placed within the framework of double-effect in the following way:

1 The action is good in itself. It acts to prevent pregnancy and sexually transmitted disease in childhood. In this sense it safeguards the health of the child.
2 The intention is solely to achieve the good effect. Though doctors' intentions are far from straightforward, there is a professional expectation (at present) that doctors do not aim for or 'purpose' the promotion of sexual activity in children. This expectation is perhaps clearer than the 'multiplicity' of intentions envisaged in the end-of-life setting.[19]
3 The good effect is not contingent on the bad effect. If a 'minor' is put off engaging in sexual activity by the advice, the benefit of the advice is not lost.
4 There is sufficient reason to permit the bad effect. This is a damage limitation harm minimisation approach. The doctor's advice is a 'palliative against the consequences of a crime', a particular phrase used by Justice Woolf in the Court of Appeal regarding the Gillick case.[20] Professional guidance from the GMC is that all opportunities should be taken to ascertain whether abuse is taking place, and action should be taken if needed, such as involvement of the parents or social services.[21] For the same reason, a clinician who supplied advice and contraception to an adult in the knowledge that this person intended to have sex with children would have difficulty explaining their actions to the courts or the GMC.

Why double effect reasoning may not work in this context

Where there is no significant foreseeable harm, the use of the doctrine of double effect is unnecessary. Outside the contexts of forced marriage and child abuse, which must be regarded as harmful, there is also evidence that sex at a young age (twice as likely if under age 15 at first intercourse) is associated with regret.[22] Whether regret can be classified as harmworthy of this form of reasoning may itself be affected by whether a child below the age of 16 is considered autonomous (in the sense of being able to make competent decisions). In the Gillick case, Lord Templeman acknowledges emotional harm and doubts 'that a girl under the age of 16 is capable of a balanced judgement' in terms of commencing a sexual relationship. If a child is not competent to make these decisions, then the scope for rape and child abuse is high. If a child is competent, then one can argue that they are entitled to make decisions which they will later regret. An oft-quoted fundamental flaw of the doctrine of double effect is its failure to recognise that the person affected by an action is the one who must evaluate the harm and benefit arising from it, i.e. it appears paternalistic.[23]

Double effect reasoning in the context of contraception creates problems for clinicians who morally object to contraception *per se*. This is on the grounds that fertility and pregnancy are not classed as 'harms'

and therefore the principle may not be applied.[24] For some clinicians, some forms of contraception are seen as equivalent to abortion as they believe that that human life starts at conception as opposed to implantation (as defined in the High Court).[25] In these circumstances GMC Guidance is that a minor who satisfies the Fraser/Sexual Offences Act criteria has a right to be able to obtain relevant advice from another clinician.

A case which should prompt further action[2]

A 15 year old girl attends your surgery requesting the morning after pill. As you check her competence, you discover that she has run away from home and is living with her boyfriend. As the girl is about to leave, you realise that she has come with a man in his late 20s.

Your receptionist also sees the man and recognises him as the one who accompanied a 14 year old girl a few weeks previously who came to see the midwife. You check the addresses of the two girls. They turn out to be the same so you contact social services and the police to find out if either girl is considered at risk or if the boyfriend or address is known to them. The boyfriend has a history of committing sexual offences. Child protection procedures are initiated.

In conclusion

The consensus statement[26] on the role of a doctor, supported by all four chief medical officers and the General Medical Council, begins, 'Doctors alone among the healthcare profession must be capable of regularly taking ultimate responsibility for difficult decisions in situations of clinical complexity and uncertainty', which is further summarised, 'Doctors must... be capable of dealing effectively with uncertainty, ambiguity and complexity'. The Fraser Guidelines are intended to deal with a scenario of particular uncertainty ambiguity and complexity. I suggest that double-effect provides a moral framework whereby clinicians can avoid legal, professional or moral complicity in an offence or harm.

Making decisions can be difficult and affords the opportunity for rationalisation and self-deception.[27] We talk of possible outcomes in terms of breach of legal, professional or moral codes or simply a bad outcome[28] for the patient. In either case, doctors, and indeed lawyers and policymakers, need to understand the legal and professional reasoning which allows clinicians to act in their patients' best interests. Clinicians need to understand their position because the 'Gillick' scenario is not uncommon. The legal cases of Gillick (and Adams) can be argued as not so much a special defence for doctors but for anyone who is repeatedly and often exposed to these dilemmas, where patient consent does not provide an adequate basis (is not enough to permit) for a course of action. The ethical reasoning behind providing sexual health advice and treatment to children could possibly be a better example of double effect reasoning than the 'end of life' scenario which is oft-quoted. This is because complicity in sexual offences against children is more clearly less acceptable than intentional life-shortening in palliative care. Clinicians who make use of this reasoning or defence should still beware of a professional and legal duty to minimise or avoid (if at all possible) foreseeable harm. It is hoped that the ethical arguments underlying this case study can help to stimulate further work on understanding of the law and guidelines which clinicians must follow in order to avoid legal liability and a heavy conscience.

CONFLICTS OF INTEREST

None.

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