

## Virtual Mentor

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### Case in Health Law

#### Must Doctors Report Underage Sex as Abuse?

by Kate Karas

Medicine and politics can be contentious bed fellows. In 2003, the Kansas attorney general issued an opinion embedding physicians with law enforcement [1]. The opinion obligated a physician to report any evidence of underage sexual activity to social services, facing criminal sanctions should he or she fail to do so. The 14-year-old patient who inquired about birth control methods, the physical examination that revealed sexual activity—both occurrences mandated that the doctor breach patient confidentiality and turn the cases over to Kansas Social and Rehabilitative Services. That the activity was consensual and between age mates was immaterial.

Physicians have long been included in state child abuse reporting statutes as mandatory reporters of suspected child abuse. All states require that persons named by statute (eg parents, physicians, teachers, etc) who suspect child abuse report the case to the particular social welfare agency charged with protecting children. In every state, it is within the physician's discretion to determine when a harm has occurred, and, thus, when his or her duties under the reporting statute. Kansas Statute § 38-1522 is the local version of the national statute: it names physicians as mandatory reporters of suspected child abuse. Failure to do so is a class B misdemeanor.

In addition to the reporting requirement, Kansas Statutory Code imposes criminal penalties on those who engage in sexual intercourse with a minor younger than 14 years of age, regardless of whether the alleged perpetrator is also a minor. Prior to 2003, however, evidence of statutory rape did not give rise to physicians' liability under the Kansas Reporting Statute unless a medical professional determined that the minor had sustained harm as a result of the sexual encounter. In fact, the former advisory opinion to the Kansas Reporting Statute, issued in 1992, specifically rejected such a blanket reporting provision as contrary to the protective purpose of the statute.

Current Kansas Attorney General Phill Kline set a new course for Kansas physicians. On June 18, 2003, he issued a second advisory opinion, stating:

Kansas law clearly provides that those who fall under the scope of the reporting requirement must report any reasonable suspicion that a child has been injured as a result of sexual abuse, which would be any time a child under the age of 14 has become pregnant. As a matter of law such child has been the victim of rape or one of the other sexual abuse crimes and such crimes are inherently injurious [1].

With this opinion, underage sexual intercourse becomes injurious per se, as a matter of law. Physician discretion is not invoked to determine whether the minor has been harmed; indeed, no medical judgment is involved. The opinion redefines the role of the physician to be that of an enforcement mechanism against statutorily illegal underage sex.

Finding this reformulation of physicians' role inimical to the treatment duty physicians have to their patients, medical professionals sued for an injunction against enforcement of the reporting scheme in the case of *Aid for Women v Foulston*. The district court granted a preliminary injunction, finding that minors possess a right to informational privacy that would be unconstitutionally compromised by the reporting statute. The final outcome of the case is pending resolution upon appeal, but developments out West offer some guidance as to how this court may ultimately find.

California offers two cases directly on point. In the 1986 case of *Planned Parenthood Affiliates of California v John Van De Kamp*, medical professionals challenged an attorney general opinion that applied the California child abuse reporting law to all sexual activity of minors under the age of 14 [2]. There, as in Kansas, a physician risked criminal liability for failure to report regardless of whether evidence of actual abuse was lacking, whether the minor was engaging in voluntary sexual conduct, and whether the activity was between age mates. The case reached the appeals level, where the judge positively affirmed 3 points of law important to physicians and health practitioners generally. First, child abuse reporting laws do not require a professional, who has no knowledge or suspicion of actual abuse, to report a minor as a child abuse victim solely because the minor is under the age of 14 and has indicated that he or she engages in voluntary, consensual sexual activity with another minor of similar age. Second, mandatory reporting of voluntary nonabusive behavior violates the right to sexual privacy guaranteed to mature minors by the California Constitution. Third, the necessitated recording of reports as envisioned by the reporting laws is in violation of informational privacy rights.

In 1988, California filed a civil complaint in *People v Stockton Pregnancy Control Medical Clinic* against a pregnancy control clinic alleging that the clinic failed to report minor pregnancies to the child protective agency in violation of the Child Abuse and Neglect Reporting Act [3]. The lower court issued an injunction prohibiting the clinic from further violating the act through failing to report. The Court of Appeal, however, reversed, holding again for health practitioners, but this time slightly narrowing the scope of the 1986 case. Specifically, the Court found that (1) the Act does not require reporting of voluntary sexual contact between minors under the age of 14 where both are of similar age, (2) reasonable suspicions of voluntary conduct between minors under the age of 14 and persons of disparate age must be reported, and (3) reporting to the child protective agency does not violate the state or federal constitutional privacy rights of minors.

The tectonic plates of policy are shifting, as evidenced by the shadow placed on the longevity of minors' currently recognized privacy rights and the trend of California courts to increasingly narrow the protections afforded minors and their health care providers. Physicians are legitimately concerned about the implications these decisions

hold for the provision of health care to a vulnerable and in-need population as statutorily necessitated breaches of patient-physician confidentiality discourage minors from seeking health care.

### **Implications of this Trend for Physicians**

Traditionally, the provision of medical services within the patient-physician relationship is insulated to the greatest extent possible from outside inquiry. The reasons for this are numerous but arise primarily from the recognition that medical information is intensely private, that the fiduciary relationship between patient and doctor is most conducive to administering the highest order of health care, and that it is crucial to public health in general and individual health in particular that persons in need of medical attention get it without unnecessary obstacles or burdens. Anticipated disclosure discourages treatment. An adolescent engaged in sexual activity who is on notice that his or her activities are subject to mandatory reporting under the criminal code may reject medical services, choosing as an alternative to perform her own abortion, forgo sexual counseling and birth control measures, or live with a treatable sexually transmitted disease in order to stay off the criminal radar. At the very least, criminal reporting discourages minor participation in the diagnostic process by posing negative incentives to the full disclosure of medical and sexual histories. The obstacles thus placed on a minor's access to health care and the physician's access to adequate information for treatment purposes, stemming from a breach of confidentiality, are dangerous to the patient, and they unnecessarily burden and impede a physician's ability to thoroughly exercise his or her professional responsibilities.

There are times, of course, when a breach of confidentiality is both medically and socially necessary. In *Tarasoff v Regents of the University of California* the court determined that when, in the course of treatment, a psychotherapist learns of a specific identifiable threat to a specific, identifiable third party, that psychotherapist has a duty to the third party to disclose that information to the proper authorities. As in the patient-psychotherapist relationship, there are exceptions that require disclosure of confidential information in the patient-physician relationship as well. The listed exceptions designated under child abuse reporting acts in particular are those in which the harm falling to the patient-physician relationship from the breach of trust is less than the harm attendant to a failure to report. Caring for the overall well-being of the patient, this determination is within the physician's and his or her professional administrator's purview of responsibility. Absent the named narrow circumstances, confidentiality is required as a prerequisite to guarantee adolescents access to and receipt of responsive and complete medical services. As quoted by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, and the Society for Adolescent Medicine, "Ultimately, the health risks to adolescents are so compelling that legal barriers should not stand in the way of needed health care" [4].

It is not simply access that the patient stands to lose, however. Just as fundamental to the provision of health services is the ability of the professional to exercise professional discretion, and this too is in jeopardy. Divestiture of professional discretion takes 2 forms: physicians lose both diagnostic capacity and their ability to balance competing medical harms in determining the course of treatment for the patient.

As to the loss of their role in diagnosing, mandatory reporting requirements that oblige medical professionals to report all incidents of underage sexual activity regardless of individual circumstance ask physicians to accept a priori that underage sexual activity is injurious, resulting in a de facto abdication of their professional responsibilities to a nonmedical law-making body. Individual determinations of harm are out the window. If the Kansas advisory opinion is allowed to stand, not only would physicians be legally required to forgo individualized medical assessment in favor of blanket reporting, they would also be positively barred from exercising judgment regarding the treatment most effective to minimize the harm to their patients.

This is not equally true of all mandatory reporting schemes. The core difference between beneficial reporting schemes and those of the Kansas variety is that the former presuppose and rely upon medical discretion. It remains with the physician to determine when there is evidence of injury or abuse, such determination then becoming the catalyst for a report to the proper authorities. It should be noted that this system does not reward or even tolerate ignorance. If a doctor does not recognize, diagnose, and report abuse when he or she should, statutory negligence and criminal fault liability come into play as a matter of course, both on the state and federal levels.

Once a person listed under a child abuse reporting statute has filed a report, the recipient department of social services decides upon the warranted response. The practice manual for each group aids in this determination, and many, like the Kansas guide, find as cause to dismiss a report the likelihood that the suspected activity is consensual relations between age mates. When, however, there is suspicion of actual abuse and harm, the agency generally interviews the child, acquiring the permission of the parent or guardian first (unless there are reasons not to obtain such permission). The protective agency may then opt to remove the child from the home, mandate counseling services for any parties involved, and may ultimately decide to prosecute the alleged perpetrator of the abuse.

The uncertainty of follow-up in the case of age-mate sexual exploration or activity leaves physicians unable to assess the harm or benefit that would come as a result of reporting and therefore denies the physician the ability to perform the mandated duties: he or she is positively unable to make an ethical determination, required by the profession and by the AMA Code of Ethics, as to how to proceed based on his or her duty to (1) help and (2) refrain from causing harm. If the report is made and the trust relationship between patient and physician breached, what is the good that comes from the breaching? What is the harm? A physician is preemptively barred from determining, with any degree of certainty, the benefit of his or her decision, given the conflicting guides under reporting statutes and social service practice guides.

Not only, then, does the public risk facing a brigade of medical professionals who are barred from addressing and diagnosing them individually to treat their specific health care needs, but it risks undermining the role, privilege, nobility, and character of the profession itself.

## References

1. Kansas Attorney General Opinion No. 03-17, The Honorable Mark S. Gilstrap (2003).
2. *Aid for Women v Foulston*. 327 F Supp 2d 1273 (2004).
3. *Planned Parenthood v Van de Kamp* 181 Cal. App. 3d 245 (1986). See also *People v Stockton Pregnancy Control Medical Clinic, Inc.*, 249 Cal. Rptr. (1988).
4. *Protecting Adolescents: Ensuring Access to Care and Reporting Sexual Activity and Abuse*. Position Paper of the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and the Society for Adolescent Medicine. Available at: [http://www.adolescenthealth.org/PositionPaper\\_ProtectingAdolescents.pdf](http://www.adolescenthealth.org/PositionPaper_ProtectingAdolescents.pdf) Accessed February 25, 2005.

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