Ethical Challenges and Guidance Related to Adolescent Pregnancy

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ABSTRACT

An emergency team was challenged with ethical issues while managing an unmarried adolescent girl who presented with an acute abdomen wherein a ruptured ectopic pregnancy was suspected. Consent remained at the center of this dilemma given the age of the patient and the nature of the issues. Herein, we deliberate upon the challenges faced by the treating team in accessing the reproductive history, obtaining consent for performing pregnancy tests and for therapeutic interventions.

Keywords: *Abortion, Ethics, Consent, Parent, Reproduction, Sexual Behavior*

By 2025, India is predicted to have the highest population of teenagers globally. Adolescence is a critical life stage characterized by profound physical, mental and emotional changes. Socio-cultural transformations and the lack of comprehensive sexuality education has led to a high-risk sexual behavior, sexual abuse, teenage pregnancies, unsafe abortions, and increased risk for sexually transmitted infections. Investing in sexual health of adolescents is the need of the hour given that pregnancy-related complications and unsafe abortions have been reported as the leading cause of death among adolescent girls [1]. Reports suggest that 15% to over 50% of adolescents in India have engaged in sexual activity before the age of 18 years [2]. Dealing with adolescent pregnancy is particularly challenging for any treatment team. Understanding the ethical concept of 'Autonomy' is a first step in dealing with adolescent girls with reproductive issues.

CASE DESCRIPTION

A 16-year-old unmarried girl was brought by her parents to the emergency room with abdominal distension, obstipation, vomiting and pain abdomen of one-week duration. Examination revealed decompensated shock, pallor, and a tender distended abdomen with absent bowel sounds. After stabilization, a diagnostic paracentesis revealed hemorrhagic fluid. Computed tomogram of the abdomen revealed dilatation of the small bowel till the ileocecal junction with a 6 cm right hetero-dense, ill-defined adnexal mass. Possibility of an acute surgical abdomen due to a ruptured ectopic pregnancy or a complicated adnexal torsion was considered and reproductive history was elicited. In the presence of her parents, the girl denied any menstrual abnormalities, vaginal bleeding, amenorrhea, or sexual activity. The child in private finally revealed a 3-week history of intermittent vaginal spotting and intake of high-dose over-the-counter estrogen pills following sexual contact 2 months ago. Urine pregnancy tests were negative and serum beta-human chorionic gonadotropin levels were equivocal at 20 mIU/mL.

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OUTCOME

Following counseling of the family and after obtaining informed consent from the parents, the adolescent girl was operated upon to find a large clotted right adnexal mass, possibly due to acute rupture of a chronic ectopic pregnancy with collections enmeshing several bowel loops causing acute small bowel obstruction. A right salpingo-oopherectomy, resection of non-viable ileal loops and loop ileostomy and laparostomy were performed. On follow up, a reversal of the ileostomy and abdominoplasty was performed, and she was well six months later.

COMMENTARIES

The above adolescent girl was cared for by an emergency surgeon (NG) whose team identified challenges and a

summary was independently shared with a Pediatrician and Ethicist (BD), a Legal Researcher (SR), and a Senior Police Officer (RPM) for discussion.

Surgeon (NG): The surgical team was faced with a child under the age of 18 years with potential reproductive issues. In such a situation, obtaining a reproductive history and testing for pregnancy requires the consent of a parent. It is common that minors refrain from discussing reproductive issues with their parents given societal inhibitions and norms regarding teenage sexual activities, or the parents may feign ignorance given social stigmatization and hassles of dealing with law, if reported to police. It was decided by the team to manage the entire family as victims and with tact. Some of the challenges were:

Stigma and discrimination: In our socio-cultural context, the need to remain empathetic while dealing with the parents if of primary concern. Resolution with repeated counseling and discussion, rather than dismissiveness and hard sermons were required. Privacy needs to be respected and assured through sensitive discussions by senior doctors with responsible family members and adolescents, both individually and together. The urgency to ensure life-saving measures always take precedence over other considerations.

Legal responsibilities: Further complicating the situation was that all underaged sexual activity, especially if a sexual assault by a known or unknown person(s), mandates reporting to the police. The team thought that if there was any such suspicion, the provisions of the Protection of Children from Sexual Offences Act (POCSO) apply [3], and the case must be registered as a medico-legal case (MLC) with information to the local police. Failure to do so may be considered an omission by the treating team and make them legally liable. In this critical situation, all concerned parties had a low threshold for an MLC. An MLC alone should not lead to procedural delays, and this was explained to the family to gain their confidence. Later, the patient was clear about consensual sex (i.e. sex that all parties involved in agree to, both prior to the sexual activity and throughout it), and the team did not register an MLC at that time. Similar full-term pregnancies have delivered to married women though obviously underaged.

Non-maleficence and beneficence: A life-saving intervention had to be performed on a critically ill minor, with outcomes ranging from risk to life, complications, cosmesis, changes in body image and future reproductive potential. Priority was always to save life.

Pediatrician and Ethicist (BD): Adolescents may be considered as mature minors depending on their ability to take responsible decisions weighing risks and benefits involved in any given situation that reflects their increasing autonomy [4]. In this scenario, the patients and the family must be taken into confidence and made to understand that the physician and the healthcare team are acting in the best interest of the child while being non-judgmental. The parents should be counseled that the team are working as co-fiduciaries along with them to attain the best possible healthcare and/or social outcome for the child in question [5]. Since the child is 16 years old, it is equally crucial to understand her wishes/feelings and give due recognition to her preferences while making any decision that will affect her in future, while following the principle of respect for '*autonomy*' and the concept of '*shared decision making*'. A written assent from the child since she is more than 12 years of age (*ethical but not legal*) along with *parental consent* is mandatory before any intervention including conducting pregnancy tests. Since unmarried pregnant girls/women and their families may be stigmatized, teams need to be sensitive while eliciting menstrual/sexual history after taking the patient and immediate family into confidence that all efforts shall be taken to maintain the privacy and confidentiality. Complying with POSCO requires the team to mandatorily inform the police if sexual activity is reported in children less than 18 years of age. One must strictly maintain confidentiality, and without any undue disclosure to any third party or media personnel to avoid stigma (*non-maleficence*). The team keeps '*beneficence*' in mind while obtaining history, performing tests, and performing any therapeutic intervention.

Legal Researcher (SR): In the case of rape, consent of the victim, including minors, must be sought before medical examination [3]. The Ministry of Health and Family Welfare (MoHFW) Guidelines for medico-legal care for survivors/victims of sexual violence recognize that children above 12 years can provide informed consent for medical examination [6]. In accordance with their primary obligation to offer treatment, the medical practitioners rightly prioritized the medical care and did not seek any First Information Report (FIR) as a prerequisite. However, doctors are under an obligation to inform the police or the *Special Juvenile Police Unit* about the commission of a sexual offence and failure to do so is a punishable offence. Since the law is silent on the time within which the information is to be given, the doctors can do so after the patient's health improves and prepare them for such reporting. Mandatory reporting intends to break the culture of silence around sexual abuse and enable children's access to support and justice. However, there are concerns that children and families will not approach doctors to avoid the matter being reported to the police and

the ensuing stigma, shame, and harassment. The Supreme Court of India has recognized the conflict between the POCSO Act, privacy obligation under the Medical Termination of Pregnancy Act, 1971, and the reproductive autonomy of minors, and has clarified that in the case of minors engaging in consensual sexual activity and seeking a termination of pregnancy, the practitioner "*only on request of the minor and the guardian of the minor, need not disclose the identity and other personal details of the minor in the information provided under Section 19(1) of the POCSO Act*." The Rashtriya Kishor Swasthya Karyakram (RKSK) standards emphasize that removing the barrier to freely access sexual and reproductive health services is the need of the hour for all adolescents and recognizes the ensuing challenges [7]. Further, doctors must be guided by the Hippocratic Oath, and must in keep in mind the best interest of the child, while adhering to legal obligations related to reporting.

Senior Police Officer (RPM): In India, 'majority' is achieved at an age of 18 years which is considered a legal age for giving a valid consent for treatment as per Indian Majority Act, Guardian and Wards Act, and Indian Contract Act [8].

- A child below 12 years (minor) cannot give consent, and parents/guardian must consent for their medical/ surgical procedures.
- A child between 12-18 years can give consent only for medical examination, but not for any procedure.
- For children who are orphans or unknown or street children, the court is appointed as a guardian and any procedure/treatment requires permission of the court.
- In case of emergency, when parents/guardians are not available to consent, a person in charge of the child like the school principal or teacher can consent for medical treatment (*loco parentis*).
- A legal age of 18 years has been set to consent for termination of pregnancy (MTP Act 1971), donation of blood and donation of organs (Transplantation of Human Organ Act 1994).

In all circumstances, it is mandatory to seek an *informed consent/refusal* for examination and collection of evidence. Consent should be taken for the following purposes: examination, sample collection for clinical and forensic examination, treatment, and police intimation. Section 164A sub-clause (7) of CrPC clearly points out that it would be illegal for anything done during medical examination which is outside the scope of consent of the patient. Consent can either be sought from the patient herself or from legally established agencies/persons acting in the best interest of the patient where the patient is unable to give consent either due to age, trauma, mental condition, or disabilities. Doctors shall inform the person being examined about the nature and purpose of examination, and in case of a child to the child's parent/guardian/or a person in whom the child reposes trust. Reading the MTP Act in harmony with the POCSO Act, the court exempted physicians from disclosing the identity of the minor in legal proceedings under the POCSO Act, noting that it would ease the tension between the legal obligation of reporting a crime, the rights of privacy and autonomy of the minor.

DISCUSSION

The focus of this scenario was *consent* and *autonomy* of children aged under 18 years. *Autonomy* derived from the Greek word *autis* (self) and *nomos* (rule), includes persons with three conditions: who decide intentionally, with understanding and without controlling influences that determine decisions. To be able to make decisions one needs to be able to weigh the pros and cons, compare the alternative options and understand the consequences, both short and long term. An adolescent's competence to make decisions and ensuring confidentiality is described in guidelines elsewhere [9,10]. 'The Rule of Sevens' suggests that children aged under 7 years lack relevant capacities and these develop between age 7 and 13 years. After 14 years it is presumed that they do have decision-making capacities. This grey area reminds us that autonomy of adolescents develops with time, and no definitive universal age exists when it is confirmed. Therefore, one is required to make individual assessments of decision-making capabilities.

Consent from children aged 12 to 18 years to elicit history and examine is a requirement. Consent for interventions requires parents to consent for this age-group. However, evolution of consent in some countries has led to minors being able to legally make decisions regarding their own healthcare; exceptions based on specific diagnostic/care categories, the mature minor exception, and legal emancipation for healthcare needs related to sexual activity including treatment of sexually transmitted infections (STIs) and provision of contra-ceptive services, prenatal care, and abortion services that has expanded over several decades [11]. Adolescent's confidentiality guidelines are less widespread. With primary prevention now available in the form of Human Papilloma Virus (HPV) vaccination, this too raises potential challenges in our settings [11].

Risk factors for early sexual intercourse have included adolescent and parental substance use, aggression and conduct disorders, decreased family attachment, high parental overprotection, poor school achievement, and

lower maternal education [12]. Trends have shown that young male adolescents have early sexual debuts, lower prevalence of condom use at first sexual experience, inclination for live-in-relationships, and alcohol consumption reflective of hazardous interconnection between such behaviors among adolescent boys which placed them at higher- risk sexual behavior as compared to young men [13].

Challenges arise as the POSCO Act mandates police reporting of every child aged under 18 years involved in sexual activity, consensual or non-consensual. One need not disclose the identity and other personal details of the minor in the information provided under POSCO except on request of the minor and the guardian. Involving parents is optimal since they are in most cases ideal to make decisions for their children as it is assumed that they care and know the needs of their children; have their own children's best interest in mind; and bear the consequences of their decisions in their continued care. However, even parents need to be competent to decide, possess adequate knowledge, be emotionally stable and committed to fulfill this role. Assent is not consent but allows respect of developing autonomy of a child. The physician must, on an individual basis, take decisions that protect the health of the child (*beneficence*, *non-maleficence*), decide on balancing consent preferably from both (Child and Parent) as well as abide by the law while documenting all decisions with rationale. Finally, one must remember that in an ideal world, all adolescents should be able to turn to parents for support and guidance knowing that families may fall 'short of the ideal'. A concern is that disclosure resulting from legal compulsion rather than flowing from family relationships interferes with communication [14].

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