

## “The best interest of the adolescent”: Exploring doctors’ decision to proceed with treatment of sexual reproductive health without parental consent

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**Introduction:** Adolescents below the age of majority require parental consent for treatment or else the treating doctor may be liable for trespass and assault. This creates a dilemma for frontline doctors, as involving parents in the discussion could add yet another barrier to the existing barriers for adolescents in terms of access to healthcare services.

**Aim:** This paper seeks to explore doctors’ treatment decisions made without parental consent when managing adolescents presenting with sexual and reproductive health issues.

**Methods:** Based on a qualitative approach, in-depth interviews with 25 doctors throughout Malaysia were conducted. All audio-recorded interviews were transcribed verbatim and analyzed using a thematic approach.

**Results:** Generally, doctors weigh any decision by examining the health risks and benefits involved. While fear of litigation influences treatment decisions, a strong adherence to the ethical duty of ‘do no harm’ outweighs other considerations. When all options are risky, choosing what is considered ‘the lesser of two evils,’ i.e., what is perceived to be in the best interest of the adolescent, is adopted.

**Conclusions:** The complexity of a medical decision related to adolescent SRH issues is increased further when legal requirements are not in synch with the ethical and personal values of doctors. The laws relating to parental consent should be promulgated with a provision allowing doctors to exercise discretion in terms of treating specific SRH issues without parental consent.

### Introduction

Studies have reported that adolescents with sexual and reproductive health (SRH) issues may be generally reluctant to discuss their health problems or access needed care. This reluctance becomes even more evident if parents are to be notified.<sup>1-3</sup> Adolescents below the age of 18 are considered to be minors and thus have no legal capacity to provide consent according to Malaysian law.<sup>4</sup> Frontline doctors face challenges when deciding to proceed with managing adolescents without the presence of parents or guardians or their consent in view of the risk of litigation and the revocation of the annual practicing certificate. On the other hand, insisting that parental consent be obtained while ignoring the adolescent’s preference increases the risk of the adolescent utilizing unsafe and illegal healthcare services in cases of pregnancy and abortion<sup>5</sup> or spreading

sexually-transmitted infections or diseases. The dilemmas faced by doctors when making treatment decisions with or without parental consent is certainly complex and real.<sup>6</sup>

Medical decision-making requires both clinical and non-clinical considerations;<sup>7</sup> a patient’s specific characteristics, both physical and non-physical,<sup>8</sup> as well as legal<sup>9</sup> and sociocultural<sup>10</sup> considerations. The doctor’s circumstances have also been recorded as influencing decision-making, shaping patterns of variation in clinical practice.<sup>11</sup> Inter-practitioners’ variations in clinical activities and practices either at the primary care or hospital level are partly attributable to doctors’ characteristics<sup>12</sup> while also depending on the clients’ individual circumstances.<sup>13</sup> Consideration of the perceived best interest of the patient in the process of decision-making is well documented in the literature, irrespective of the pros and cons of its application.<sup>14</sup>

Despite the abstract and subjective nature of its application, the best interest of the patient has been an important theme in decision-making, particularly in the case of end-of life decisions.<sup>15</sup> The benefits and burdens of decisions in term of the diagnosis and treatment of the patient are considered<sup>16</sup> when determining what is in the best interest of the patient. In this regard, it has been suggested that the question of to treat or not to treat should be addressed by offering an approach consistent with an understanding rooted in the traditional medical ethics of autonomy, beneficence and the sanctity of life.<sup>17</sup> However, it is not clear how doctors apply these ethical principles within the legal mandate for parental consent. Hence, understanding doctors' experiences in dealing with adolescent SRH cases is pertinent when exploring their exercising of discretion and treatment decisions made without parental consent. An understanding of the complexity of the decision-making undertaken by frontline doctors and how well the current laws are serving the needs of the community can facilitate a reshaping of the current legal requirements for the benefit of all.

### Methods

We conducted in-depth interviews using a semi-structured interview guide with doctors practicing at the public and private health facilities throughout Malaysia. They were recruited using purposeful sampling based on their gender, religion, postgraduate qualifications and practice experience, particularly in dealing with adolescents' SRH, through which a snowball technique was adopted. Saturation of the data was achieved at 19 participants. However, further interviews were conducted to confirm the findings. Ethical approval was obtained from the Medical Research and Ethics Committee (MREC) of the Ministry of Health through the National Medical Research Register (NMRR-13-1564-18750 (IIR)). The participants were supplied with a formal letter and necessary documents, such as the Respondent Information Sheet and the Informed Consent Form for an interview and audio recording. Participants' backgrounds have been kept confidential and anonymous.

The in-depth interviews and written documents, legal or otherwise, were used to triangulate the data, in particular those relating to the understanding of and practice concerning the consent requirement, while field notes were used reflectively during data analysis. The interviews were audio recorded

and transcribed verbatim. The completed and checked transcripts were imported to QSR NVivo Version 10 to assist with data management and analysis. Analysis included reading, sorting, analyzing and categorizing the textual data in the transcripts.

Two researchers worked on five transcripts and agreed on a coding framework. The first author then proceeded with the analysis of the rest of the transcripts, along with frequent discussions with the other researchers. The data was explored by reading the texts repeatedly to truly understand participants' descriptions of their experiences, followed by a more detailed 'open coding' accomplished by reading each and every line of the interview transcripts. During this first coding cycle, various text segments that shared similar meaning were put under the same codes while others were given new codes. Further analysis involved the identification of similarities and differences among the codes within the same transcript. This process involved the reorganization and reconfiguration of the codes in order to develop a smaller and more select list of broader categories. At this stage, codes were recoded as needed and then similar codes were assembled together under the same broader category in order to analyze their commonalities. The various categories were then compared in order to see what connections, similarities and differences existed between them. Then similar categories were clustered under one theme.<sup>18</sup> The themes developed for the first analyzed transcript were used later to help orient the subsequent analysis. In analyzing subsequent transcripts, comparison was made not only to the codes and categories within the same transcript but also to the codes and categories across other transcripts.

### Results

#### Participants' profile

The 25 participants were recruited from different parts of Malaysia and had clinical experiences ranging in duration between 13 and 50 years. There were 11 primary care physicians. The rest were specialists including obstetricians, paediatricians, adolescent health specialists and reproductive health specialists. Nine male doctors and 16 female doctors participated. Five participants were from the private sector, two were from the University hospital, one came from a statutory body and the remaining 17 were attached to either primary care clinics or public hospitals.

### Ethical duty outweighs legal duty

Fear of legal consequences was reported as an influence on participants' decisions when managing adolescent issues. The perceived legal duty mandating parental consent placed doctors in a stressful and difficult situation, partly because survival in medical practice is tied to the medico legal scenario.

*"I would be worried to breach that actually, where the guardianship law says that for a child or anybody, whatever you want to do needs consent."* [Dr. H]

*"Because our annual practicing license and everything is tied to the medical legal scenario, ... you can be subjected to a Malaysian Medical council inquiry and your (practicing) license is at risk."* [Dr. G]

Although the legal age of majority (18 years old) becomes the first consideration, as it is specified in the law, other aspects surrounding each particular case are also considered and, at times, outweigh the age factor if the circumstances necessitate intervention.

*"So, if positive for STI, immediately treat. If pregnant, immediately provide antenatal care. If you look at the law, it is as if we cannot treat without parental consent, but actually, we have been doing it for quite some time."* [Dr. T]

The most compelling influence when deciding on whether to provide care without parental consent is the perceived 'ethical duty' that is strongly related to the Hippocratic Oath. There is a perceived responsibility and duty to prevent, in good faith, any harmful risk and complication to the health of an adolescent patient regardless of parental consent. As such, the participants feel that they are duty bound to take care of the health of the adolescents despite acknowledging the fact that any such intervention with regards to underage adolescents without parent consent is in contravention of the culture and the law.

*"As medical professionals, we are bound by our Hippocratic oath. We don't deny any medical assistance in term of even providing counseling and all that. We are bounded to that. That is our first priority, I suppose. Then probably the next one comes to the issue of legality. So, whether it is legally permissible or not, probably that will be the second issue."* [Dr. A]

### Do no harm

The basic, yet most powerful ethical principle held by the participants in their medical practice is 'do no harm.' Although there was no single definition of 'do no harm' stated, it is extensively understood to extend beyond treating physical health to all other related

matters affecting an adolescent's general health and wellbeing directly. In applying this principle in their medical practices, the participants try to strike a balance between the risks and benefits of pursuing the treatment of adolescent patients.

*"...because, actually, in the Hippocratic Oath, the first is do no harm, that is the first thing. If you cannot give good, do not harm the patient."* [Dr. T]

*"My conscious will say I must not harm the patient and if I feel that by not giving the patient the treatment, I might harm the patient, then it is wrong. Sometime, by withholding treatment purely on a point of law, you can be harming the patient."* [Dr. D]

The "do no harm" concept extends beyond the health of an individual adolescent to include others, particularly in cases of sexually promiscuous adolescents.

*"Considering the fact that STI is very virulent, very fast spreading and it can spread among their close contacts, whoever they have intimate contact with will have it. That probably would be the first priority: to ensure that the infection will not cause any damage to them."* [Dr. A]

Participants also consider the potential harm to the adolescents in terms of certain parental reactions towards SRH issues. Hence, parental involvement is avoided if the participants perceive risks to the adolescent of receiving harmful parental treatment that then would lead to further negative implications.

*"Probably some of them, like MSM (men having sex with men), would result in being kena buang (disowned) and so forth. I think this is more dangerous, more harmful to the patients. They become depressed, become suicidal and so forth. So, it depends on the situation."* [Dr. Q]

### The lesser of two evils

The participants reported the possibility of negative perception from the community that adolescents are being encouraged to engage in more sexual activity when contraceptives are provided. Among the Muslim participants, all but two of them did not consider religion to be a hindrance to providing services to adolescents without parental consent, particularly in the case of providing contraception to a sexually active adolescent, as this is considered as less 'evil' than allowing adolescents to face the risk of pregnancy, abortion, abandoning their baby or even becoming a child abuser.

*"You give contraception as if you encourage sexual intercourse, but when you think about when they have sexual intercourse and have delivered and abandoned the child, which one is worse? So, you*

*have to take which one is better than the worst one.” [Dr. W]*

Moreover, the adverse outcome of not providing contraception that resulted in an unintended pregnancy reportedly results in higher risks of looking for an alternative, yet unsafe, mode of terminating the pregnancy.

*“We run a risk of them not wanting to come to us and going to quacks. That is the sad thing. Going to quacks meaning they are not doctors, they will do illegal abortions. So, my worry is if we are going to be so rigid and say look, every case has to involve the parents, they may end up going to quacks and that is a dangerous thing.” [Dr. H]*

### **The best interest of the patient**

The best interest of the adolescent patient matters the most and is perceived to be in line with an express provision in the Convention of the Rights of the Child (CRC), to which Malaysia is a state party.

*“So, I was very happy to do it for her because I felt that it was in her best interest. I always follow the CRC in the best interest of children.” [Dr. M]*

However, there seem to be differences in the participants’ perceptions as to what constitutes the best interest of the adolescent patient. One participant feels that by putting herself in the position of the adolescent’s mother and treating the patient like her own son or daughter, she will be able to do the right thing and make the best decision for the health of the adolescent patient.

*“So, my approach will be like: if this is my daughter, how would I be doing it?” [Dr. P]*

The first approach views the best interest of the adolescent patient as primarily dependent on the health and specific circumstances of each adolescent. For a medically trained professional, the best interest of the adolescent patient is perceived to be best served by ensuring that the state of the patient’s emotional and physical health is safe and healthy. In the case of a suspected pregnancy, for example, a urine pregnancy test or ultrasound scan provides confirmation of an adolescent pregnancy. Allowing the adolescent to be examined regardless of parental consent provides an opportunity for uncovering more teenage pregnancy cases. As such, early interventions, such as a safe termination of pregnancy or antenatal care, could be offered.

*“Then you can uncover a lot of teenage pregnancies at the early stage. Rather than close the door, they don’t come in, so you open the door and give them options.” [Dr. F]*

According to this view, providing proper

ante-natal care and follow-ups, even without parental consent, are perceived to be in the adolescent’s best interest because of the risks involved in teenage pregnancy.

*“When we talk about specifically about pregnancy, teenage pregnancy, the priority is the patient, because pregnancy is not without risk and that risk is greater if she is a teenager. And so taking into account the best interest of the patient is the reason why we focus on treating the adolescent as any other pregnant patient.” [Dr. T]*

In contrast to the above perspective, there are some participants who seem to be pro-parent. They embrace a ‘protective’ approach in the sense that the best interest of the adolescent patient is best served if their welfare, safety and health is taken care of. Further, those goals are achieved only by involving parents in his or her healthcare. According to this view, parental consent is needed when dealing with an adolescent patient, not because of legal implications but rather because, through this, parents would have knowledge of the adolescent patient’s health condition, could provide support and would be responsible for post-treatment care.

*“I never give treatment without the parents. Because, to me, parents must know because should anything happen, who will take care of the child? You get what I mean? So, it’s more on that part, rather than protect me, you know. It’s more to protect the child.” [Dr. C]*

*“I want the parents to be there to be aware, so that they can support them throughout.” [Dr. O]*

In addition, parental involvement will ensure continuity of care and supervision of the adolescent’s health and behavioral issues, particularly of those who are involved in risky behavior, such as being sexually active. This involvement is seen as necessary because the doctor sees the patient for a very short period of time; thus, there needs to be someone at home who will look after the adolescent’s general health and well-being, as well as their sexual behavior, in order for the intervention to succeed.

*“Let me tell you, the patient sees you for one to two hours, right? If parents are not involved, how is this child going to be help? The child is going back to the family. I need the family to be my eyes and ears. If I don’t get the family involved, then I know my therapy is going to fail. So, you need the parents there.” [Dr. H]*

This type of reaction comes about because of the perceived inability of the adolescent to suddenly stop the habit unaided. The reasoning goes that the possibility of adolescents reverting back to practicing healthy behaviors

through parental involvement and continuous supervision and care is higher than if the adolescents are left to their own devices.

*“Parents’ involvement is very important. At least if the parents know the status of their own children, actually there is space for them to revert. Otherwise, they tend to repeat. Things get repeated and never end.”* [Dr. U]

*“(If) parents do not know what is actually happening in their (adolescent’s) life, they can easily go back to whatever they are doing.”* [Dr. I]

### Discussion

Decision-making in medicine is rarely simple, even in so-called simple cases. To assume otherwise is to misjudge the task of medicine and the power of organized medical knowledge and medical care.<sup>19</sup> While various studies have explored the influence of clinical and non-clinical factors at the doctor and patient level, as well as the environment of the practice setting,<sup>7-13</sup> this study adds to the existing knowledge about how those various competing factors are reconciled in the process of making decisions.

Certainly, fear of litigation influences treatment decisions. In a different study context, doctors were found to select much more conservative treatments for their patients than for themselves on the basis of the legal consequences of the decisions.<sup>9</sup> Other studies reported that fear of litigation may influence doctors’ decisions regarding end-of-life care and resuscitative efforts<sup>20</sup> and those decisions which involve surrogate or family concerns.<sup>21</sup> However, the participants in this study have apparently examined and treated adolescents without securing parental consent in various circumstances regardless of their understanding of the law, particularly those adolescents who are found to be sexually active.

Although there is no hard and fast rule adopted by the participants in the process of making decisions regarding whether to provide healthcare services with or without parental consent, it is found that in weighing and reconciling the various factors, the participants give more weight to their ethical duty to ‘do no harm.’ The emphasis is placed on the health risks and benefits involved in the decision and choosing the ‘lesser of two evils’ while being guided by the principle of the ‘best interest of the adolescent.’ This stance is consistent with the World Medical Association International Code of Medical

Ethics, which states that ‘a physician shall act in the patient’s best interest when providing care, the interest of the patient should always be promoted regardless of financial arrangements, the healthcare setting or patient characteristics such as decision making capacity, behavior or social status’<sup>22</sup> The Convention on the Rights of a Child, to which Malaysia is a party, provides that the best interest of a child is a paramount consideration.<sup>23</sup>

While there is no definitive and consensus meaning of ‘do no harm’ and ‘best interest of the patient’ among the participants, this study found that these guiding principles were found to have been applied quite extensively, i.e., not limited to the aspect of physical health only. As the literature indicates, consideration of the best interest of the patient in a medical intervention is not necessarily limited to therapeutic intervention.<sup>24</sup> In term of saving lives or ensuring improvements or preventing deteriorations in patients’ physical or mental health,<sup>25</sup> consideration of the best interest extends to broader ethical, social, moral and welfare considerations.<sup>26,27</sup> It is apparent that those who are pro-parent and against adolescents be given the right to consent on their own had, in some instances, provided clinical interventions without parental consent, particularly for those suffering from STIs and/or in need of contraception because of their sexually active behavior. Similarly, those who seemed to be pro-adolescent have, in certain instances, decided that the adolescent requires supervision in order to ensure the successful treatment of the health condition, such as in the case of HIV/AIDS. Hence, the participants are all in agreement about not giving the absolute right to consent to the adolescent as well as not abstaining them absolutely from consenting under proper circumstances.

In the context of contraception and abortion, the application of ‘the lesser of two evils’ dominates clinical judgments in terms of providing the necessary interventions. Although providing contraception may be misperceived as an encouragement for an adolescent to be sexually active, not providing the same will expose them to contracting an STI and, in the case of girls, pregnancy. In terms of the termination of a pregnancy, the majority of the participants are of the view that terminating the pregnancy within the ‘safe period’ under the supervision and care of a healthcare professional is better than

allowing the same intervention to be carried out by untrained people, baby abandonment or child abuse to take place.<sup>28</sup> Pregnancies with their associated risks, particularly among young mothers,<sup>29</sup> and the spread of STIs are both perceived as greater evils that need to be prevented from occurring. Physicians' social characteristics, including their religious values, are reported to have an influence on their decision-making.<sup>30</sup> However, no obvious differences were found among Muslim participants and between Muslims and non-Muslim participants in this study in terms of their decision-making. This finding is similar to the findings of a different study that indicated that religiousness showed little variation and emerged as an insignificant independent variable in terms of the physicians' decisions.<sup>31</sup>

#### **Study limitation**

The participants are all specialists identified through the snowballing technique, thus limiting the ability to choose possible participants that best provide information for or against parental consent. Nevertheless, the differences that are present in the socio-demographics of the participants provide great diversity in terms of their exposures and experiences, both as previous medical doctors and current specialists in dealing with adolescent patients with SRH problems. Such variations have provided different perspectives on the phenomenon researched, leading to findings of high quality, detailed descriptions of the phenomenon and elucidation of significant common and shared patterns within that variation.

#### **Conclusion**

Making treatment decisions based on the ethical principle in contravention of the

legal mandate for parental consent places the medical practitioner at risk of litigation and/or facing disciplinary action affecting his or her medical practice. However, as this study found, the complexities and dilemmas involved in making decisions concerning adolescents with sexual and reproductive health issues without parental consent extend beyond the age factor. What is best for the adolescent patient involves doing no harm by choosing what is medically perceived to bring more benefits and the 'lesser evil' to the health and wellbeing of the adolescent patient. Perhaps the law should be promulgated to acknowledge the complexity of the situation and to bestow certain discretionary authority to the medical practitioners to provide necessary intervention without parental consent in justified circumstances, particularly, in the case of the sexually active adolescent.

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#### **Author Contributions**

Farah Nini and Iriane conceived the initial research idea. Iriane conducted all the interviews and analyzed the data together with Sajaratunisah. Both Iriane and Sajaratunisah drafted the paper with feedback from Farah Nini.

#### **Conflicts of Interest**

The authors declare no conflict of interest.

#### **How does this paper make a difference to general practice?**

1. This paper highlights the challenges of managing adolescent health, in particular, sexual reproductive health (SRH), for doctors in ambulatory settings.
2. This paper provides an understanding of doctors' decision-making processes as they try to fulfill the requirements of the law and local health guidelines on adolescent SRH.
3. The findings will initiate an evaluation of the current related policy and law taking into consideration the challenges faced by health service providers.

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