Legal and clinical issues with doctors’ criminal law duty to report consensual sexual activity between adolescents

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Primary Keywords [Office use only]: Ethics and law; General medicine; Health occupations; Health services administration; Pediatric medicine; Sexual health; Social Determinants of Health; Women’s health

Secondary keywords [Office use only]: Confidentiality; General practice; Adolescent medicine; Legislation, medical; Adolescence; Child abuse; Sex offenses; Patient rights; Women's rights; Contraception

Notes:

This is the author manuscript accepted for publication and has undergone full peer review but has not been through the copyediting, typesetting, pagination and proofreading process, which may lead to differences between this version and the Version of Record. Please cite this article as doi: 10.1002/MJA2.51163

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<td>22/09/2020</td>
<td>Accept</td>
<td>25/02/2021</td>
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### Wiley – file data:
- Filename for copyediting: `mat_mja20.01749_ms`
- Accompanying graphics
- Stock images
- Supporting information: `mat_mja2.00000-sup-0001-supinfo`

### Office use – history:
- Proof sent to author
- Proof returned by author
- Published (date format `xx/xx/xx`): 02/08/21
- Issue: 3
- Vol: 215
- DOI: 10.5694/mja2.01749

## Journal
- **The Medical Journal of Australia**

## Original article DOI (for response)
- 10.5694/mja2.01749
Doctors’ criminal law duty to report consensual sexual activity between adolescents: legal and clinical issues

Legal, clinical and ethical problems with laws requiring doctors to report consensual adolescent sexual activity

Many Australian teenagers engage in consensual sexual intercourse with similarly aged peers. They require confidential medical care, including contraception and sexually transmitted infection testing. However, adolescents’ rights to access medical care may confront legal barriers.

In several Australian states and territories, new criminal laws require adults to report sexual offences against children. Other criminal laws make it an offence for adolescents aged under 16 years to engage in sexual intercourse. Accordingly, a question for clinical practice is whether the new criminal law reporting duty applies to adolescents’ confidential communications regarding consensual sexual activity. Law, ethics and practice must protect children, but must not criminalise consensual peer sexual activity or compromise clinical care.

Here, we review literature regarding adolescents’ lived experience, findings from developmental science, and analyses of consensual and lawful sexual activity. We conduct a comparative analysis of Australian criminal law reporting duties for child sexual offences. We identify situations where laws inappropriately require clinicians to report adolescent sexual activity, and we make recommendations for reform.

Background

A 2018 national survey found 47% of 14–18-year-olds engaged in vaginal or anal intercourse, including 34% of those in Year 10. For most Year 10s (aged 14–16 years), the most recent sexual partner was a peer aged under 17 years (92%). However, 6.5% of sexually active Year 10s reported their most recent partner was aged 18–19 years. Of Year 10 females, over one-third (37%) had engaged in intercourse, and for 10% of these their most recent partner was aged 18 years or older.

General practitioners were the most trusted source of sexual health information, from whom 40.6% of females sought clinical advice. Clinician engagement was further evidenced by 43.5% of females using the contraceptive pill. However, adolescents experience multiple barriers in accessing health services, including perceived lack of
confidentiality, and youth friendly service guidelines recommend confidential care approaches.\textsuperscript{2-4}

The \textit{Lancet} commission on adolescent health acknowledged the complex interplay of adolescent neurodevelopment and legal principles of capacity.\textsuperscript{5} Australian legal milestones differ, indicating how laws attempt to attain policy goals while grappling with scientific knowledge: 10-year-olds can be liable for criminal offences; 15-year-olds can obtain a Medicare card; and 17-year-olds can drive. Developmental neuroscience has shown adolescents aged 15–16 years possess adult-like cognitive ability,\textsuperscript{8,9} while psychosocial and neurobiological maturity continues into the mid-20s.\textsuperscript{9} It has been shown that, especially when in “calm and emotionally-neutral contexts”,\textsuperscript{5} adolescents possess cognitive capacity to weigh costs and benefits and make reasoned judgements about courses of action, including about consenting to medical treatments involving contraception and sexual health.\textsuperscript{6,7} Much consensual peer sexual activity occurs in such settings; even in more emotionally “hot” circumstances, the capacity to consent to sex with similarly aged peers is consistent with findings from developmental neuroscience.

**Legal requirements for consent, and the age of consent**

Lawful consent to sex requires full, free and voluntary agreement, and the absence of threat, intimidation and abuse of power (Box 1). Social science models of child sexual abuse are similarly premised on consent requiring full, free, voluntary and uncoerced participation.\textsuperscript{10}

Laws must navigate a tension between protecting the developing adolescent and respecting and promoting their capacity and autonomy.\textsuperscript{11,12} In this setting, legislatures, as the bodies in each state and territory able to pass and amend criminal laws (legislation), must protect children and youth from sexual abuse, while allowing consensual peer sexual activity in both heterosexual and same-sex relationships. Currently, the legal age of consent prohibits intercourse with minors under a specified age, presuming that children under this age lack capacity to provide true consent. This age is 16 years in most jurisdictions (Box 2). Legal defences embody legislatures’ acknowledgement that sex between adolescents may be consensual and permissible. Criminal laws in five jurisdictions provide a close-in-age defence to offences where the act involves consenting people who are both minors aged under 16 years or are similar in age (Box 2).

**Prosecution guidelines**

Similarly, official guidelines in every jurisdiction\textsuperscript{13,14} regarding prosecution of criminal offences recommend against prosecuting consensual activity between minors. These guidelines acknowledge it is against the public interest to prosecute these cases, because of the oppressive consequences, and the trivial and merely technical nature of any breach. Victoria’s guidelines are particularly strong, and specifically refer to situations where both adolescents are under 16 years of age, and where they are aged 15 and 18 years: a
prosecution is contraindicated where a young person “has committed an offence in the context of a consenting sexual relationship with another young person [including] sexual penetration of a child under 16 where the offender is 18 and the complainant is 15”. In such cases, prosecutors should consider: the adolescents’ ages and maturity; whether they are in a relationship; whether they consented; and whether the person wishes a prosecution to proceed.

In our hypothetical clinical case of Anna and David (Box 3), a prosecutor should conclude that despite technical commission of an offence (due to Anna and David being 15 and 18, respectively), prosecution should not occur because they are mature, near-aged peers in a consenting sexual relationship with no coercion. They were responsibly acting to obtain contraception and advice from a medical practitioner, and Anna would not want David prosecuted. Prosecution is against the public interest for reasons including adverse effects on adolescents’ willingness to seek medical advice, which may result in further consequences including unintended pregnancies, sexually transmitted infections, and effects on education, employability and health.

Criminal law reporting duties

Child protection legislation has long required professionals to report sexual abuse to child welfare agencies. Recent inquiries into institutional abuse and cover-ups catalysed recommendations for new reporting duties in criminal law, applied to all adults. Victoria, New South Wales, the Australian Capital Territory and Tasmania have since enacted new reporting duties in criminal law, advancing social norms to protect children. Queensland has recently enacted a duty, which has not yet commenced. (Supporting Information, Table 1).

These laws require adults to report information to police about a sexual offence committed against a child. To accommodate exceptional circumstances and navigate ethical tensions, exceptions apply to requests of non-disclosure, and confidential disclosures (Supporting Information, Table 1).

Comparative analysis: six dimensions of legal inconsistency and uncertainty

The relevant laws differ between jurisdictions, and exceptions are of uncertain application. Comparative statutory analysis reveals that for medical practitioners treating adolescents in consensual peer relationships, the laws present six problems.

First, only NSW expressly excludes medical practitioners from the duty to report sexual offences against children (Supporting Information, Table 1). This creates a clear inconsistency: NSW practitioners are exempt from the duty, while their counterparts elsewhere are not. However, exempting NSW practitioners may mean sexual offences are less likely to be reported.

Second, three jurisdictions apply the duty to report sexual offences both to situations involving two minors aged under 16 and to situations involving a minor and an adult. In
contrast, Victoria only applies the duty to situations involving a minor and an adult. Accordingly, Victoria’s duty is narrower, acknowledging that otherwise it may inappropriately embrace consensual behaviour; yet it is important not to discourage Victorian practitioners from reporting non-consensual sexual offences between minors, so this limit may be suboptimal. The problem elsewhere is the duty may capture consensual peer activity.

Third, only Victoria excludes the duty where the adolescent “victim” aged 16 or 17 requests non-disclosure. Elsewhere, this exemption applies only to requests by victims aged 18 or over. This creates inequality in recognising adolescent capacity and autonomy.

Fourth, the concept of a “reasonable excuse” for non-reporting is not exhaustively defined (Supporting Information, Table 1). It is unclear whether a reasonable excuse for non-disclosure includes a medical practitioner’s choice not to report a confidential disclosure in a therapeutic setting of consensual acts constituting a sexual offence. This leaves practitioners in all jurisdictions unsure whether they would be legally protected for not reporting.

Fifth, Victoria, NSW and Tasmania enable prosecution only if approved by the Director of Public Prosecutions. This suggests multiple situations do not warrant prosecution. However, it is not clear when approval would be given, leaving clinicians in doubt about exemptions to the duty. The ACT lacks this mechanism, indicating higher likelihood of prosecution.

Sixth, health professionals may be exempt from the duty where a patient confidentially discloses a sexual offence (Supporting Information, Table 1). This exemption is founded on the concept of professional confidential relationship privilege. However, these exemptions are unclear, rely on networks of laws, and apply to different practitioners. Tasmania and the ACT lack clear confidentiality exceptions (Supporting Information, Table 2). NSW has a clear exemption. Victoria has an express exemption if the information is a “confidential communication” as defined by other legislation (Box 4). However, in Victoria, the exemption applies only to communications from the younger adolescent (Box 4). In Anna’s hypothetical case, David attending the consultation would technically trigger the GP’s duty to report (Box 3).

Discussion

The new duties in criminal law to report sexual offences against children are consistent with policy values in protecting children, and with bioethical principles of justice and beneficence. Requiring adults to report child sexual offences is justified by diminishing harm to individuals, and by enhancing community protection and a protective social fabric for vulnerable children. Sexual activity between adults and children should generally be considered abusive, due to absence of consent and presence of coercion. However, legislatures must ensure an appropriate balance between protecting children and youth from sexual offences, and recognising their capacity and promoting autonomy, privacy and freedom of expression. Genuinely consensual sexual activity between under-aged minors is not abusive. In addition, a grey zone of cases may involve two
adolescents aged almost 16, and 18. Here, where sexual activity may be genuinely consensual, ethical analysis, findings from developmental science, and clinical needs all suggest the duty should be moderated by nuanced individual consideration by clinicians (Box 3). In our view, the central concept that should inform legal principles and practice is consent, and its presence or absence in circumstances which do not involve threat, intimidation or abuse of authority. On our analysis, three conclusions seem clear.

First, legislative reforms are required so that disclosures in therapeutic contexts of clearly consensual sexual activity between similarly aged peers under 16 are expressly exempt from the reporting duty. This is consistent with policy animating Victoria’s law reform requiring adults to report “a serious indictable offence involving the abuse of a child”,16 and Royal Commission recommendations.17 If protected by such an exemption, clinicians consulting with adolescents who are having sex with similar aged peers can be unhindered in providing preventive health interventions including contraception for mature minors, and screening for sexually transmitted infections.18 Clinicians routinely enquire about age of sexual partners and otherwise consider risk of abuse and patient capacity when providing treatment.7 If they reasonably conclude the adolescents are consenting, confidential treatment should be provided and this is clearly incompatible with reporting to police. Such an exemption also allows clinicians to create a safe environment to encourage adolescent help-seeking, check for other health risks,19 explore family dynamics, and connect the adolescent with parents or others to benefit wellbeing.18,19

Second, this legislative exemption could extend to clearly consensual activity between adolescents aged 15 and 18. Legal attribution of capacity to consent to sex using simple age cut-offs is convenient, but sometimes incongruent with developmental science, lived experience and clinical scenarios.9 In situations of clearly consensual activity, a margin of error should favour patient autonomy and clinical care. This is consistent with prosecutorial guidelines and Tasmania’s similar age exemptions. Clinicians would prefer this slight extension of the exemption so they can promote health and encourage future help-seeking. Our hypothetical patients Anna and David would be unwilling to seek future care if the GP reported David to police.

Third, the different models for exempting clinicians as recipients of confidential information are complex, uncertain and unsatisfactory. Legislative reforms are required to create a clear, unified approach. Any legislature that wants to include an exemption for confidential disclosures about abusive incidents made to medical practitioners within therapeutic contexts should enact a specific exemption, using the NSW model. This would solve difficulties ascertaining whether this constitutes a “confidential communication” or is protected by privilege. It would also solve problems in the requested non-disclosure exemptions; for abusive incidents, application only to those over 18 is inconsistent with developmental science, which suggests Victoria’s age 16 is justifiable, and could be extended to those aged 15.

This three-pronged approach aligns with clinicians’ duty of confidentiality in codes of ethics,20 and organisational policy on sexual and reproductive health.21 National
principles recognise medical practitioners’ central role in supporting sexual and reproductive health through confidential care, with youth a priority population.\textsuperscript{18,21}

This medico-legal context is increasingly complex. Our analysis has focused on adolescent peers in genuinely consensual relationships whose ages mean technically they are committing an offence, exemplified by peers aged 15 and 18 years (Box 1). We unequivocally support duties to report child sexual abuse,\textsuperscript{15,22} and do not here consider other situations where different outcomes may transpire. We also caution that where disclosures of abusive incidents may be exempt from the criminal duty, a clinician may have a separate overriding legal duty to report. For example, Victorian doctors may be exempt under s 327(7)(c) of the \textit{Crimes Act 1958} from disclosing a 10-year-old’s confidential disclosure of sexual assault, but must report under child protection legislation.\textsuperscript{15} Health practitioners therefore need to know their responsibilities under different laws, and need ongoing professional education to promote legal literacy.

Progress towards reform may require several steps. Since legislative limitations differ, agencies representing medical practitioners could urge reform at state and territory level, informed by research and clinical experience. However, ideally, a harmonised national approach should be adopted. National medical regulatory bodies and government ministries could mobilise to support a single model law that balances the need to protect Australian children from sexual offences, while promoting adolescents’ rights to consensual sexual activity.

\textbf{Competing interests:} No relevant disclosures.

\textbf{Provenance:} Not commissioned; externally peer reviewed.

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\texttt{doi: 10.5694/mja20.01749}

\section*{References}


[Boxes]
### 1 Requirements of consent to sexual intercourse, by Australian states and territories

#### Conditions for consent to sexual intercourse

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<thead>
<tr>
<th>Jurisdiction</th>
<th>Free and voluntary agreement</th>
<th>Not by threat, intimidation, or abuse of authority</th>
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<tr>
<td>Australian Capital Territory</td>
<td><em>Crimes Act 1900, s 67</em> (not expressly defined)</td>
<td>s 67(1): consent to sexual intercourse with another person is negated if that consent is caused: <em>(a)</em> by the infliction of violence or force on the person, or on a third person ...; or <em>(b)</em> by a threat to inflict violence or force on the person, or on a third person ...; or <em>(c)</em> by a threat to inflict violence or force on, or to use extortion against, the person or another person; or <em>(d)</em> by a threat to publicly humiliate or disgrace, or to physically or mentally harass, the person or another person; or <em>(h)</em> by the abuse by the other person of his or her position of authority over ... the person</td>
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<tr>
<td>New South Wales</td>
<td><em>Criminal Code Act 1983, s 192(1): “consent means free and voluntary agreement”</em></td>
<td>s 61HE(5)(c): A person does not consent to a sexual activity if the person consents “because of threats of force or terror (whether the threats are against, or the terror is instilled in, that person or any other person)” s 61HE(8): “The grounds on which it may be established that a person does not consent include ... (b) if the person consents to the sexual activity because of intimidatory or coercive conduct, or other threat, that does not involve a threat of force, or (c) if the person consents to the sexual activity because of the abuse of a position of authority or trust”</td>
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<td>Northern Territory</td>
<td><em>Criminal Code Act 1899, s 348(1): consent means consent freely and voluntarily given by a person with the cognitive capacity to give the consent</em></td>
<td>s 192(2): “Circumstances in which a person does not consent to sexual intercourse ... include circumstances where: <em>(a)</em> the person submits because of force, fear of force, or fear of harm of any type, to himself or herself or another person”</td>
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<td>Queensland</td>
<td><em>Criminal Law Consolidation Act 1935, s 46(2): “a person consents to sexual activity if the person freely and voluntarily agrees to the sexual activity”</em></td>
<td>s 46(3): a person does not freely and voluntarily agree to sexual activity if <em>(a)</em> the person agrees because of <em>(i)</em> the application of force or an express or implied threat of the application of force or a fear of the application of force to the person or to some other person; or <em>(ii)</em> an express or implied threat to degrade, humiliate, disgrace or harass the person or some other person; <em>(b)</em> agrees or submits because of force, or a reasonable fear of force, to him or her or to another person;</td>
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<td>South Australia</td>
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<td>s 2A(2): “a person does not freely agree to an act if the person ... <em>(b)</em> agrees or submits because of force, or a reasonable fear of force, to him or her or to another person;</td>
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<tr>
<td>Tasmania</td>
<td><em>Criminal Code 1924, s 2A(1): “consent’ means free agreement”</em></td>
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or (c) agrees or submits because of a threat of any kind against him or her or against another person; or ... (e) agrees or submits because he or she is overborne by the nature or position of another person”

Victoria  

Crimes Act 1958, s 36(1):  
“consent means free agreement”

s 36(2): “Circumstances in which a person does not consent to an act include, but are not limited to, the following—(a) the person submits to the act because of force or the fear of force, whether to that person or someone else; (b) the person submits to the act because of the fear of harm of any type, whether to that person or someone else”

Western Australia  

Criminal Code Compilation Act 1913, s 319(2)(a):  
“consent means a consent freely and voluntarily given”

s 319(2)(a): “a consent is not freely and voluntarily given if it is obtained by force, threat, intimidation, deceit, or any fraudulent means”

2 Close-in-age defence for sex with a minor under the legal age of consent, where intercourse is consensual

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<th>Jurisdiction</th>
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<th>Age of consent</th>
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<td>Australian Capital Territory</td>
<td>Crimes Act 1900, s 55(2)</td>
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<td>Crimes Act 1900, s 66C(3)</td>
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<td>Criminal Code Act 1983, s 127(1)</td>
<td>16</td>
<td>No</td>
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<td>Criminal Code Act 1899, s 215(1)</td>
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<td>No</td>
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<tr>
<td>South Australia</td>
<td>Criminal Law Consolidation Act 1935, s 49(3)</td>
<td>17</td>
<td>Yes — if accused was under 17, and child was 16: ss 49(4)(a) and (4)(b)(i)</td>
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<td>Tasmania</td>
<td>Criminal Code Act 1924, s 124</td>
<td>17</td>
<td>Yes — age gap not more than 5 years, if child was aged at least 15: s 124(3)(a); and age gap not more than 3 years, if child was aged at least 12: s 124(3)(b)</td>
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<tr>
<td>Victoria</td>
<td>Crimes Act 1958, s 49B</td>
<td>16</td>
<td>Yes — if accused was not more than 2 years older than the child, and the child was aged 12 or over: s 49V</td>
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<tr>
<td>Western Australia</td>
<td>Criminal Code Act 1913, s 321(2)</td>
<td>16</td>
<td>No</td>
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</table>
3 Hypothetical clinical case study

- Anna is 15 years of age and in Year 10 at a co-educational high school in Victoria. She has been getting good grades and has a part-time job at a supermarket. David is 18 years of age, in Year 12 at Anna’s school, and works at the same supermarket. They have been dating for 3 months. Anna presents to her general practitioner for contraceptive advice. She has become sexually active with David and wants contraception additional to condoms. Her GP confirms Anna is a mature minor, since she understands fully the range of contraceptive options open to her, how they work, and their side effects. She has carefully considered all options with David, and has chosen a long-acting reversible contraceptive implant. She intends to inform her mother, but she is not quite ready yet. She is certain she does not want to experience an unintentional pregnancy. Anna describes her relationship with David as very positive. She feels completely safe with him and under no coercion. She feels she could stop the relationship at any time if she wanted to, and so could he.

The age of consent for sexual intercourse in Victoria is 16. Where sex involves a minor aged 12–15, no offence is committed if the other person is less than 2 years older than the minor, and the sex is consensual. Technically, David is committing a sexual offence by having sex with Anna, because he is 3 years older than her; if he was 17 there would be no offence. However, the GP is satisfied this relationship is consensual, and previously would not have reported this situation under either criminal law or child protection law. However, the criminal law on failure to disclose that commenced in Victoria in 2014 has now presented a dilemma for the GP. These laws aim to protect children from sexual abuse and require adults to report knowledge of a sexual offence with a child under 16 years to police. Anna has not expressly stated to the GP that she does not want the situation reported to police, since it has not occurred to her that anything wrong has happened.

- The GP studies the government website on the new laws to understand what she should do. She is relieved to learn health practitioners are exempt from the criminal law duty to report if they are told about the offence in the course of a confidential consultation. However, because of other legal definitions (Box 4), this exemption only applies if consulting exclusively with the person against whom the offence has been committed. The next day, Anna and David consult the GP together for a baseline sexually transmitted infection screen. The GP was happy to see them, but was perplexed that the exemption did not apply if consulting with the offender, in this case David. She was very reluctant to call the police about David and Anna, due to her knowledge about the consensual nature of their relationship, and their responsible behaviour in obtaining contraception. The GP also understands that other adults who know about the situation, such as Anna’s and David’s parents and school teachers, would appear to be required to report by the criminal law duty, since no clear exemptions apply to them.

4 Health Practitioner Regulation National Law: definitions and application

- In Victoria, a “confidential communication” is “a communication, whether oral or written, made in confidence by a person against whom a sexual offence has been, or is alleged
to have been committed to a registered medical practitioner or counsellor in the course of the relationship of medical practitioner and patient or counsellor and client": Evidence (Miscellaneous Provisions) Act 1958, s 32B.

- Under the Health Practitioner Regulation National Law Act 2009 (Qld) Schedule s 5, "health practitioner means an individual who practises a health profession". A "registered health practitioner means an individual who (a) is registered under this Law to practise a health profession, other than as a student; or (b) holds non-practising registration under this Law in a health profession". A "health profession" is defined to include a list of 15 professions (including recognised specialties in these), and most relevantly here includes the following professions: medical, nursing, pharmacy, and psychology.

- In Victoria, a "registered medical practitioner" under the Health Practitioner Regulation National Law is defined through the application of the Health Practitioner Regulation National Law Act 2009 (Qld) Schedule s 5. Victoria incorporated the Queensland Act into Victorian law, through the Health Practitioner Regulation National Law (Victoria) Act 2009, s 4 (Application of Health Practitioner Regulation National Law).


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Title:
Doctors' criminal law duty to report consensual sexual activity between adolescents: legal and clinical issues

Date:
2021-07-18

Citation:

Persistent Link:
http://hdl.handle.net/11343/298758