

Confidentiality and the adolescent patient

Doctors may find themselves in an invidious position, trying to balance loyalty to family against confidentiality.



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Confidentiality is an agreement between a doctor and a patient that information discussed during or after a consultation will not be divulged to other parties without the patient's explicit authorisation.¹

Without assurances of confidentiality patients may be unwilling to give doctors the information they need to provide good care. This article examines the scope and limits of confidentiality in the case of adolescent patients.

Suggestions that adolescents should be allowed to make medical decisions without parental consent or knowledge are controversial,² despite evidence that adolescents may avoid seeking medical care if they think doctors will inform their parents.³ While most young children are probably not capable of making independent medical decisions without their parents' awareness, this may not be the case for teenagers whose decisional capacity and maturity vary widely from early to late adolescence. Furthermore, the extent and legitimacy of parental involvement in adolescents' medical treatment during the transitional period between childhood and adulthood are uncertain. Consequently, doctors treating adolescents may face a dilemma when balancing adolescents' interests in receiving appropriate, confidential care and parents' wishes to know about the condition of their minor children and to make decisions regarding their care.¹ To illustrate some of the issues that may arise in clinical practice consider the scenario shown in the box.

In South Africa, a child is any person under 18 years of age.⁴ In this article adolescents are broadly defined as being between 12 and 17 years of age.

Chantal is a bright 16-year-old who presents to her general practitioner (GP) with vague symptoms of nausea and lethargy. She tells her GP she is in a sexual relationship with a university student whom she has been dating for 6 months. She requests a prescription for oral contraception. She pleads with the GP not to tell her parents, who feel 'the relationship is too serious'. The GP has known Chantal since she was 3 years old. Should the GP prescribe contraception without informing her parents? Should he persuade Chantal to involve her parents? What if she refuses? What if she is pregnant?

REASONS FOR CONFIDENTIALITY

Confidentiality promotes trust between patients and doctors. Adolescents will only share sensitive or potentially damaging information if they trust their doctors to safeguard it. By allowing patients control over who has access to personal and intimate information, confidentiality promotes full and honest disclosure.

Adolescents are particularly reluctant to seek help for sensitive issues such as contraception, pregnancy, sexually transmitted infections and substance abuse unless their confidentiality is assured.¹ If adolescents doubt their doctors' willingness to respect confidentiality they may withhold information, delay seeking care or refuse care.¹ Therefore, a primary reason for medical confidentiality is to ensure timely, accurate diagnosis and treatment to protect adolescents' health and often the public health as well.

Apart from its beneficial consequences, confidentiality holds special value for ado-

lescents because of their unique developmental needs, particularly their desire for adult status and psychological separation from their parents. As adolescents assume increasing responsibility for their lives they look less to parents for approval and validation of their choices. Indeed, an important part of growing up is learning to make decisions on one's own. Arguably, the psychological requirements for becoming an independent, self-sufficient adult provide '... a basis for a distinctively adolescent right to privacy and confidentiality', especially from parents whom, rightly or wrongly, adolescents perceive as intruding in their private lives.⁵

LIMITS OF CONFIDENTIALITY

However, adolescents are not yet adults and their transitional status affects the scope of confidentiality. As long as adolescents are part of a functioning family it can be argued that they are legitimately subject to parental guidance and supervision.⁵ What then is the scope of confidentiality during adolescence? What considerations might justify a doctor's decision to reveal confidential information to a parent? Adolescents' maturity, the potential for harming themselves and others because of their behaviour, and parents' interests in their adolescents' decisions are pertinent to disclosure.⁵

Maturity

With regard to medical decisions, maturity is usually defined in terms of competence or capacity to decide. A person is considered competent if able to understand a problem or intervention, to weigh the risks and benefits of different options, to weigh the likely short- and long-term consequences of each option, and to express a preference.⁶ Empirical data show that from about 14 years of age adoles-

cents possess the necessary intellectual and psychological skills to make medical decisions to a degree comparable with adults.⁷ There is also explicit legal recognition of minors' competence to consent. In terms of the Child Care Act 74 of 1983, a child over 14 years is legally competent to consent to any medical treatment (excluding surgery) without the assistance of a parent or guardian.⁴ Moreover, the South African Law Commission has recommended that the age at which children may consent to medical treatment be lowered to 12 years.⁴ Therefore, on empirical and legal grounds adolescents should be presumed competent to make medical decisions on their own.

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Still, even intellectually competent adolescents may have shortcomings in their decision-making capacity. What counts as a risk or benefit in a medical decision would depend on the adolescents' values. Conceivably, adolescents' current preoccupation with, among other things, physical appearance and peer acceptance may partially impair their judgement, leading them to give inadequate weight to the effects of decisions on their future interests. Hence, present benefits of decisions may receive disproportionate weight compared with potential long-term outcomes. Insofar as adolescents do not have

the perspective needed to evaluate adequately the lasting significance of their immediate concerns, they might be considered immature. Even so, adults should be slow to consider such age-appropriate values and concerns as misguided merely because they differ from their own.⁵

Potential harm to self

Although on balance adolescents should be presumed capable of making medical decisions this does not mean their expressed wishes may not be overridden if the doctor deems it in their best interests. The onus rests on the doctor to establish if a particular adolescent is mature enough to make a particular decision.⁶ Since competence is decision-relative, adolescents may be mature enough to make some decisions but not others; where to draw the line will depend on the nature and consequences of the decision at hand. The more adverse the expected consequences of respecting the adolescent's wishes, the more certain the doctor must be that the adolescent possesses the necessary maturity.⁶ Inevitably there will be some decisions few adolescents are mature enough to make because the risks (i.e. the likelihood and severity of potential harm) are too high.⁵ With this in mind, there will be some risks against which adolescents need protection.

When an adolescent's actual or intended choices are dangerous or life-threatening, a doctor may justifiably breach confidentiality. Moreover, the mismatch between the likelihood and severity of harmful consequences and the adolescent's lack of appreciation of these risks together with his tenuous grasp of the future, may justify breaching confidentiality.⁵ The decision to disclose confidential information is justified on grounds that the harm prevented is greater

MAIN TOPIC

than the wrong caused by violating the doctor's moral duty to maintain confidentiality. Circumstances in which confidentiality may be broken include suicidal ideation, serious substance abuse, life-threatening medical conditions (such as eating disorders) and disclosure of physical or sexual abuse.¹ Should the clinician encounter a situation where disclosure is in the adolescent's interests, there is still a moral duty to respect the adolescent as a person. To this end, the doctor needs to inform the adolescent first and, if possible, include the adolescent in the process of revealing the confidential information.¹

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Even if agreed that an adolescent's well-being is best served by breaching confidentiality, the doctor must still decide to whom he will disclose the private information. In particular, is the doctor obliged to tell the adolescent's parents?

Scope of parental involvement

Parental involvement in adolescent decision-making can be justified on grounds of their right to know and the benefits of their knowing.⁵ An important social difference, often regarded as morally relevant, between adults and adolescents, is that adolescents generally live with their parents and are financially dependent on them.⁶ Parents might argue that since they bear the

financial and other consequences of their minor child's medical choices they should have some input into those choices. If indeed parents have a right to know, they ought to be involved in their adolescents' medical decisions unless there are compelling reasons not to. In other words, there is a moral presumption in favour of parental involvement.⁵ Alternatively, there is the view that doctors should favour confidentiality until there are convincing reasons not to; until, that is, the benefits of involving parents outweigh the harms of breaching confidentiality.⁵ If, for instance, an adolescent has a serious drug-abusing habit, successful treatment may depend on parental collaboration. On balance, where adolescents are sufficiently mature and legally able to make independent medical decisions, the presumption ought to favour confidentiality.

The doctor should elicit the reasons for an adolescent's insistence on confidentiality and he/she must assess the accuracy of these perceptions. Because adolescents fear parental disapproval, they may underestimate the support their parents can provide. Consequently, without evidence to the contrary, clinicians should at least encourage adolescents to involve parents in their medical decisions.⁵

There will be times when adolescents adamantly refuse to involve their parents, or any adults, in their care. There will also be unfortunate situations where parents are neither interested nor willing to become involved. If the consequences of no treatment outweigh the risks of treatment without an adult family member, the doctor's therapeutic duty will require treatment of the otherwise unsupported adolescent.⁵

For practical purposes the doctor should pre-emptively raise issues of confidentiality with the family dur-

ing early adolescence. The doctor can explain that in the future the adolescent will be interviewed alone for part of each visit. At the same time, the doctor can reassure the parents and inform the adolescent that confidentiality will be broken if the adolescent's life or safety is at risk. The adolescent also needs to know that confidentiality is reciprocal and parents too may want to share their concerns with the doctor.¹ If confidentiality issues are addressed in advance, there may be less tension should they manifest during adolescence.

Questions raised in the case scenario

There are many reasons why Chantal may not want her parents to know she is sexually active. Maybe she is embarrassed or fears their disapproval — if they find out, they may insist that she end the relationship. The GP must weigh the short- and long-term, medical and psychosocial consequences of prescribing oral contraception. The GP must decide if Chantal is competent enough to make the request on her own. Chantal is already sexually active, so even if the GP questions her maturity, he may decide to prescribe contraception on pragmatic grounds. If pregnant, Chantal may want to carry the pregnancy to term or have an abortion. Either option carries physical and emotional consequences. If she continues to insist on confidentiality, the GP ought to respect her decision since, at 16, she likely has sufficient maturity and understanding to judge what is in her best interests. Still, the GP should encourage Chantal to discuss her situation with her parents or another adult. He might offer to tell her parents or be present if she agrees to tell them personally. Chantal is legally able to consent to an abortion as well as request contraception. (The Choice on Termination

of Pregnancy Act 92 of 1996 allows pregnant girls of *any* age to consent to their own abortion without the knowledge or involvement of their parents.) At 16, she has also reached the legal age of sexual consent. Therefore her parents' consent is unnecessary. Nevertheless as a trusted family doctor, the GP may face a conflict of professional loyalties if he feels he is colluding with Chantal behind her parents' backs.

Confidentiality in adolescent care is necessary for developmental reasons and to protect the adolescent's health.

CONCLUSION

Confidentiality in adolescent care is necessary for developmental reasons and to protect the adolescent's health. However, confidentiality may be overridden where there is clear justification such as risk of serious harm. In general, adolescents should be encouraged but not forced to involve their parents in their medical care.

References available on request.

FURTHER READING

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IN A NUTSHELL

Confidentiality bars doctors from disclosing information entrusted to them without patients' explicit permission.

Adolescents seek confidentiality because of their unique developmental needs.

Adolescents are unlikely to seek medical care for sensitive conditions unless confidentiality is assured.

Adolescents should be encouraged but not forced to involve their parents in their medical care.

Doctors should pre-emptively inform adolescents and their parents about the requirements of confidentiality, including conditions under which it may be breached.

Confidentiality may be breached in exceptional circumstances, such as risk of serious harm to the adolescent.

Should it become necessary to breach confidentiality, the doctor should inform the adolescent first and try to include him/her in the process of disclosure.

SINGLE SUTURE

New markers to determine prognosis in acute coronary syndromes

Elevated levels of the biomarkers C-reactive protein (CRP) and B-type natriuretic peptide (BNP) recently have been shown to predict outcomes in acute coronary syndromes. Now, investigators have combined testing for these biomarkers with testing for troponin I to investigate the utility of all 3 biomarkers in combination (*Circulation* 2002; **105**:1760-1763). BNP, CRP, and troponin I were measured in 450 participants from a multicentre trial of patients with non-ST-segment-elevation MIs. Each biomarker was an independent predictor of the primary composite endpoint of death, myocardial infarction, and heart failure. A simple additive score, devised from the number of positive biomarkers, was used to categorise patients. The researchers then tested this scoring system in a larger cohort of patients who were enrolled in the TACTICS-TIMI 18 study. In 1 635 patients, the number of elevated markers again was a significant independent predictor of outcome. Six-month relative risk for the composite endpoint was 3.6 among patients in whom all 3 markers were elevated, compared with those in whom all biomarkers were normal.

This study provides strong evidence that the new biomarkers BNP and CRP complement standard testing for troponin for predicting outcomes in patients with acute coronary syndromes. Such additive benefit may be attributable, in part, to the different nature of each marker: troponin predominantly indicates myocardial necrosis, CRP indicates inflammation, and BNP indicates activation of the neurohormonal axis.

(Fleischmann K E. *Journal Watch* May 21, 2002.)