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Primary care confidentiality for Spanish adolescents: fact or fiction?

M D Pérez-Cárceles, J E Pereñíguez, E Osuna, D Pérez-Flores, A Luna

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See end of article for
authors' affiliations

Correspondence to:
Assistant Professor
M D Pérez-Cárceles,
Department of Legal and
Forensic Medicine, School
of Medicine, University of
Murcia, E-30100
Espinardo, Murcia, Spain;
mdperez@um.es

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Background: By providing healthcare to adolescents, a major opportunity is created to help them cope with the challenges in their lives, develop healthy behaviour and become responsible healthcare consumers. Confidentiality is a major issue in adolescent healthcare, and its perceived absence may be the main barrier to an adolescent seeking medical care. Little is known, however, about confidentiality for adolescents in primary care practices in Spain.

Objective: To ascertain the attitudes of Spanish family doctors towards the right of adolescents to confidentiality in different healthcare situations and in the prescription of treatment.

Method: A descriptive postal questionnaire was self-administered by family doctors.

Results: Parents of patients under 18 years are always informed by 18.5% of family doctors, whereas parents of those under 16 years are informed by 38.8% of doctors. The patients are warned of this likelihood by 79.3% of doctors. The proportion of doctors supporting confidentiality for adolescents increases with the age and maturity of the patients, whereas workload and previous training has a negative effect.

Conclusions: Spanish laws on adolescent healthcare are not reflected by the paternalistic attitude that Spanish primary care doctors have towards their adolescent patients. Doctors need to be provided with up-to-date and clinically relevant explanations on contemporary legal positions. In primary care, more attention should be paid to adolescents' rights to information, privacy and confidentiality. Doctors should be more aware of the need to encourage communication between teenagers and their parents, while also safeguarding their patients' rights to confidential care.

In recent years, problems associated with adolescent health have become much more complex. At the beginning of the 20th century, the most common causes of mortality and morbidity were of a biological nature, and although disease pathologies continue to be the most frequent cause, the past century has seen an increase in others, including violence, sexual behaviour, suicide, substance misuse and eating disorders, both in the US and in European countries.^{1–3}

Studies on the knowledge, attitudes and practices regarding health issues of adolescents among medical professionals have been carried out mainly in the US.^{4–5} Other studies have dealt with attitudes towards confidentiality among doctors who treat adolescents, with most professionals agreeing that adherence to rules of confidentiality can ensure better healthcare provision.^{6–7}

Unfortunately, adolescents have few options to turn to for confidential and sound advice when attempting to make healthy behavioural decisions. Healthcare providers represent one such source, and their effectiveness in influencing their patients positively is directly related to the trust developed in the patient–provider relationship.⁸ Key to a productive encounter between the adolescent and the healthcare professional is the assurance that the sensitive information that passes between them will not be divulged to anyone, including parents.^{9–11} Services that are not considered confidential are considerably less likely to be used by young people.¹²

Adolescent medicine is a subspecialty in several European countries, but not in Spain, where family doctors are charged with providing healthcare to people once they have reached 14 years of age. Doctors in Spain and in many other countries, however, do not receive any formal training (whether at undergraduate or postgraduate level) in this discipline despite this being a major obstacle to achieving

adequate adolescent healthcare.¹³ Primary-care doctors refer to low levels of perceived competence in subjects such as sexuality, eating disorders and drug misuse,¹⁴ and point to the need for further training in these disciplines.^{15–16} Those who work with young people must have a clear understanding of consent and confidentiality and also ensure that the services they work in have policies and practices that increase confidentiality and competence among teenage patients.¹²

Current Spanish law (Law 41/2002) allows people ≥16 years to give independent consent before receiving care, although in certain circumstances they need to be 18—for example, for techniques of assisted reproduction, voluntary interruption of pregnancy and participation in clinical trials. However, it is admitted that the intellectual and emotional ability of the adolescents to understand the implications of treatment is possible and, therefore, their consent could be valid opinion, despite being under 16. Also, the law states that in situations of grave risk and in accordance with the doctor's decision, parents should be informed and their decision taken into account. The law generally upholds the decision of the provider who, in specific cases, assesses the competence of adolescents to be sufficiently mature to take decisions. As a result, a degree of uncertainty still exists in daily practice, and the situation is not so different from that before the new law was passed.¹⁷ Similar situations arise in other countries—for example, Jacobson *et al*¹⁸ mention the confusion of healthcare professionals in the UK on the concept of competence in younger teenagers following the Gillick ruling.

Despite several studies showing that lack of confidentiality is a barrier to adolescents' use of healthcare services,^{19–23} little is known about confidential care for adolescents in primary care practices in Spain. We found no reference to the

behaviour and attitudes of family doctors in Spain with regard to adolescents and confidentiality.

The purposes of this study, therefore, were to (a) ascertain when family doctors inform the parents of adolescents and (b) evaluate the degree of confidentiality afforded by these professionals in different healthcare situations and in the prescription of treatment for adolescents.

METHODS

Type of study

We conducted a cross-sectional survey previously approved by the ethical research committee of the regional health authority.

Study population

The size of the sample was initially 385, calculated with a population proportion of 0.5, a precision of 5% and a confidence level of 95%. The final sample, however, consisted of 227 family doctors, which represents a response rate of 59%. Of the 72 primary healthcare centres in the province of Murcia (southeast Spain), we obtained replies from 56 (77.7%) centres.

Source and collection of data

Data were obtained by means of a self-administered validated questionnaire. The actual questions were formulated during a brainstorming session comprising seven family doctors who treated patients over the age of 14 in Spain and three university teachers from Legal Medicine at a state university (Murcia), whose teaching included Medical Law and Bioethics.

To evaluate the validity of the content, we also consulted psychologists, teachers and parents before piloting the questionnaire, 30 family doctors were chosen to pilot and validate the questionnaire, and they too made suggestions that led us to omit or change some items. Cronbach's α test was applied to the results ($\alpha = 0.89$).

The first part of the questionnaire had 11 items defining socioprofessional conditions (table 1). To evaluate the information provided by the doctor, we chose the following questions and possible answers:

- When do you inform the parents of adolescents? (a) Always when they are under 18, (b) always when they are under 16, (c) always when they are under 12, (d) never without the patient's authorisation.
- When your patient is an adolescent, do you warn them that you will provide information to their parents? (a) Always, (b) when they are over 14, (c) when they are over 15, (d) when they are over 16, (e) never.
- Do you inform the parents of adolescents about potentially harmful practices their children may be engaged in? (a) Always, (b) never, (c) in some cases.

We evaluated the frequency (never, sometimes, almost always, always) with which family doctors informed the parents of adolescents in the following situations: (a) life-risking situations, (b) pregnancy, (c) sexual transmitted diseases, (d) infectious-contagious illnesses, and (e) HIV seropositivity.

We also evaluated the degree of agreement (by Likert scale) on providing information to parents of adolescents about the use of tobacco, alcohol, hashish, heroin or cocaine.

Finally, we ascertained the frequency (never, sometimes, almost always, always) with which family doctors inform the parents of adolescents (divided into two age groups, 14–15 and 16–17 years) after prescribing the following treatments to adolescents who attended their surgery unaccompanied by adults: (a) anti-inflammatory drugs, (b) antibiotics, (c)

psychotropic drugs, (d) diet, (e) hygiene habits and (f) contraceptives.

The questionnaires were mailed to 385 family doctors chosen in a stratified random way from the 554 practising family doctors in the province of Murcia. The questionnaires were completed on a voluntary and anonymous basis.

We estimate that each family doctor in the region treated an average of 368.6 adolescents a year between 2002 and 2004 (SD 94.18; range 237.8–643.2).

Statistical analysis

Data were analysed with SPSS V.11.0, by using simple distribution of frequencies, association between variables (Pearson's χ^2 test) and the McNemar test for intergroup comparison.

RESULTS

Socioprofessional characteristics

Table 1 summarises the socioprofessional characteristics of the sample. As we found no significant differences in the socioprofessional variables of the respondents and non-respondents, we assume that there is no bias in the replies.

Most of the professionals who completed the questionnaires were aged 36–55 years (84.6%), the number of men was double that of women, most were married and most had children. As regards the length of service, the largest group (52.4%) consisted of those who had been in practice for 11–20 years. At the time of filling in the questionnaire, 30% had been in their present post for less than 3 years and 26% between 3 and 5 years. Family doctors who had held their post for more than 15 years represented the lowest percentage (11%) of replies. Most doctors (49.8%) worked in practices in towns of 5000–15 000 inhabitants.

The professional training of the doctors included an internship specialising in family and community medicine (49.8%), covalidation of specialties by participating in different courses (30.4%) or transfer from other specialties (19.8%). Most were exclusively employed in the public sector. The number of patients on each doctor's list varied from 1901 to 2100 (32.6%) and 20.3% had fewer than 1500 patients. In the main (35.7%), the family doctors saw 41–50 patients a day. Roughly half the doctors practised in health centres that served as government-accredited centres for inducting new

Table 1 Socioprofessional characteristics of the sample

Age in years, mean (SD)	44.2 (7.14)
Male (%)	64.3
With children (%)	73.1
Married (%)	78.9
Years in practice, mean (SD)	17.8 (7.55)
Work environment (%)	
Urban (>15 000 inhabitants)	29.1
Semiurban (5000–15 000 inhabitants)	52.4
Rural (<5000 inhabitants)	18.5
Previous training (%)	
Family doctor (internship)	49.8
Family doctor (other ways)	30.4
Other specialties	19.8
Type of practice (%)	
Public	92.1
Public and private	7.9
Number of patients on list, mean (SD)	1786 (295.24)
Number of patients seen daily (%)	
30–40	18.9
41–50	35.7
51–60	29.5
>60	15.9
Work in a training health centre (%)	49.8%

family doctors, and 70.9% dedicated 4–6 h a day to seeing patients.

Providing information to the parents of minors

Approximately 18.5% of doctors provide information to parents when the patients are under 18 years old, 38.8% when the patients are under 16 and 19.4% when they are under 12. About 23.3% of family doctors say they only provide information to parents when authorised to do so by the patient.

Table 2 shows the personal and professional profiles of family doctors who always inform the parents of patients under 16. The professionals who always inform the parents of 16–18 year olds see an average of >50 patients a day (66.7%; $p=0.002$) and have >1700 patients on their list (80.9%; $p<0.001$).

When these patients attend surgery unaccompanied by adults, 79.3% of the doctors tell them regardless of the adolescents' age that their parents will be informed, 7.9% warn them of the same if they are ≥ 14 , 1.3% if they are ≥ 15 and 8.4% only if they are ≥ 16 years of age. Around 3.1% of the doctors never inform their young patients that they will tell their parents. The profile of the family doctor who always warns adolescents that their parents will be informed is as follows: specialist trained in family medicine (49.4%; $p<0.001$), sees <50 patients a day (59.5%; $p=0.011$) and is <45 years old (65.6%; $p<0.001$).

Figure 1 shows the frequency with which family doctors inform parents of adolescents in certain situations without previously asking permission.

The highest percentage (90.3%) of doctors would always inform the parents when the situation is life threatening, whereas the lowest percentage (17.6%) would do so in the case of sexually transmitted diseases. Approximately 57.7% of doctors would inform the parents in cases of general risk (for example, sexual practices, substance misuse, and dangerous eating habits), whereas 6.2% would never do so in such situations.

A Likert scale showed the degree of agreement as regards providing information to parents on the consumption of different substances: tobacco, 3.58 (3.40–3.76); alcohol, 3.97 (3.81–4.13); hashish, 4.03 (3.86–4.19); and heroin or cocaine, 4.27 (4.12–4.41). Figure 2 shows the percentage of doctors who consider it very important to inform the parents about the consumption of these substances and the significant differences in this evaluation.

Table 3 summarises the significant differences, according to the socioprofessional characteristics of the family doctors, in the importance given to informing parents about consumption of drugs.

When adolescents attend surgery unaccompanied by adults, the frequency with which doctors inform parents about prescribed treatments varies according to the age of the

Figure 1 Frequency with which doctors inform the parents of minors in certain healthcare conditions.

Figure 2 Percentage of doctors who consider it very important to inform the parents on the consumption of tobacco, alcohol, hashish and heroine or cocaine, and the significant differences in this evaluation.

Table 2 Profiles of family doctors who inform the parents of patients under 16, when the patients attend surgery unaccompanied by adults

	Percentage	p Value
Under 45 years old	50.2	0.002
Male	67	0.026
With children	73.9	0.032
Semiurban environment	62.5	<0.001
Previous training: internship in family medicine	47.7	0.007
Number of patients on list <1700	90.1	<0.001
Number of patients seen daily <50	68.2	0.002
Training centre	43.8	0.033

Pearson's χ^2 test was used.

patient and the treatment concerned. Figure 3 shows the percentage of doctors who always or almost always inform the parents of these patients without previously asking permission.

DISCUSSION

Young people regularly attend general practice because its person-centred approach deals with all health issues and it is therefore ideally suited to their needs.²⁴ In several surveys, adolescents said that they had visited a healthcare service in the previous year, mainly as a source of primary care.^{25–26} Some studies, however, showed that a substantial percentage of adolescents did not seek care or advice because they did not want their parents to find out about their ailment.^{20–27}

Table 3 Percentage of family doctors who give most importance to informing parents about drug consumption by children

		Tobacco	Alcohol	Hashish	Heroin or cocaine
Age (years)	≤ 40	49.2	50.8	66.7	76.2
	41–54	29.1	42.6	41.9	46.6
	≥ 55	50	56.3	100	100
p Value		0.010	NS	<0.001	<0.001
Marital status	Married	39.1	63	55.3	63.1
	Single	28.6	28.6	42.9	42.9
	Separated	22.2	45.3	44.4	40.7
p Value		NS	NS	NS	0.027
Previous training	Family doctor internship	29.2	32.7	38.9	50.4
	Family doctor (other ways)	40.6	59.4	60.9	63.8
	Other specialties	46.7	57.8	75.6	71.1
p Value		NS	<0.001	<0.001	0.034
Number of patients seen daily	30–40	32.6	32.6	34.9	39.5
	41–50	46.9	46.9	63	66.7
	51–60	53.7	53.7	44.4	53.7
	>60	44.4	63.9	63.9	72.2
p Value		NS	NS	0.008	0.007

NS, non-significant.
Pearson's χ^2 test was used.

Despite this, Kraus *et al*²⁷ found that confidentiality, which is of utmost importance to young people, was not included in the top-10 list of topics considered to be important for their practice by different medical specialists.

The family doctors comprising our survey were representative of the general situation of the profession in Spain. They were mainly men, middle aged, married and with children. They were in the midst of their careers, had a wealth of accumulated experience and worked mainly in semiurban or rural communities and solely for the local health service. Their workload may be considered excessive, as judged from the large number of patients on their lists and the number of patients they see every day, which may have had a negative effect on other types of activity that may also be considered to be within the competence of primary care doctors.

Many doctors do not apply the principle of confidentiality to their adolescent patients and are not aware of the types of service for which adolescents can provide their own consent. Usually, the legal right to consent to treatment resides with the adolescent's parent or legal guardian. There are, however, many cases in which adolescents may provide their own consent. Adolescents also have the right to confidentiality in almost all situations in which they have the right to consent.

Figure 3 Percentage of doctors who always or almost always inform the parents of adolescents when prescribing different treatments.

In the US and several countries in Europe, there is an increasing awareness of the need for confidentiality, although the tendency is to obtain the agreement of teenagers for parental involvement. Our findings confirmed this. Despite a new law in Spain (41/2002) giving patients ≥16 years old the right to give consent to any medical treatment without parental involvement, almost 20% of doctors always inform the parents of 16–18 year olds. This suggests that doctors are unaware of the new legislation, or that despite it they still wish to involve parents in the healthcare of their young patients. Possibly, the attitudes of Spanish parents in general have had a role (73.1% of the respondents had children), as they are considered to be much more protective than parents in other countries, and children also tend to leave home at a comparatively late age. This also affects the ability of young people to make decisions, especially those about their health. Despite their engagement in health-risk behaviour and their concerns about health, adolescents have the lowest rate of health service utilisation of any age group. Time constraints during routine medical encounters generally leave little opportunity for professional screening of any behaviour that may represent a health risk or for discussing psychosocial problems.^{14–28} On analysing the profile of the typical family doctor who provides information to parents of 16–18 year olds, we found older doctors with a heavy workload, which limits the time available for individual attention. On the other hand, and with less paternalistic attitudes, those who provide information in accordance with the law—that is, only to the parents of adolescents <16 years of age—tend to be younger, have children and have a lighter workload. As was seen in a study of family doctors in Israel,¹⁵ it seems that the younger generation of doctors in Spain is more prone to accept adolescents as sensible people, and therefore to agree to observe confidentiality in various health issues than the older generation of family doctors.

When adolescents attend surgery unaccompanied by adults, most doctors (79%) tell them that they will inform their parents. These doctors tend to be younger and see fewer patients. Ford and Millstein²⁹ found that doctors reported discussing confidentiality during routine visits with 53% of their adolescent patients. In agreement with Graham *et al*,³⁰ young people need to be informed of widespread adherence to current guidelines on confidentiality, although in Spain, the issue of confidentiality has not been sufficiently clarified by law or by the medical community.

Most lifelong health choices are decided at adolescence and clinicians can help adolescents make healthy choices to ensure a safe, secure future. Analysis of several specific healthcare situations for adolescents showed that in situations representing a grave health risk for their patients, doctors tend to be least bound by the rules of confidentiality, 97.3% always or almost always informing the parents, in accordance with Spanish law.

In most Spanish provinces, family planning for adolescents is provided by family doctors in primary care centres. In the case of HIV infection, pregnancy or risky practices, most (almost 60% in each case) doctors informed the parents of their adolescent patients, whereas in the case of sexually transmitted diseases and other infectious or contagious diseases, confidentiality was mostly maintained.

As regards confidentiality and the consumption of different substances, despite the general tendency to inform parents, this tendency grew in the case of tobacco but was less in the case of heroin or cocaine. Young doctors trained in family medicine and with a lighter workload tended to respect confidentiality to a greater extent, whereas married doctors with children (76.5%) were more likely to inform the parents, probably because they would like to be informed in similar situations.

As regards the information offered to the parents of adolescents attending surgery unaccompanied by adults, doctors always or almost always provided information on the prescription of psychotropic drugs to 14–15 year olds (87%), whereas the greatest degree of confidentiality was maintained in the case of contraceptives (29%). In similar situations with 16–17 year olds, our results agree with those of Lovett and Wald,⁶ as the proportion of physicians supporting confidentiality increased with the age and maturity of the adolescents.

Limitations of the study

To generalise delicate situations by using a scale is difficult, but we consider that we have uncovered some of the relevant attitudes. More indepth research is needed, and the use of scenarios may help.

As no similar studies are available in the bibliography for Spain, our findings cannot be compared; further studies will therefore need to be undertaken. Moreover, this study is limited to public health services and cannot therefore be extrapolated to private practice. About 75% of the Spanish population as a whole use public health services and the remaining 25% use private companies, although the proportion of people that use private services has increased gradually in recent years.

The importance of organisational factors has been studied by several authors, but we did not find any papers dealing with the influence of workload when evaluating patients' rights.

CONCLUSIONS

Our results suggest that the attitudes of primary care doctors towards confidentiality for adolescent patients do not totally reflect Spanish laws on adolescent healthcare and can be considered paternalistic. This research highlights the need for general practitioners to be given up-to-date and clinically relevant explanations of contemporary legal positions. Establishing written rules of practice with regard to policies on adolescent confidentiality may help in improving access to care for adolescents as a result of the increased confidence that adolescents will feel in the doctor–patient relationship.

The health service must begin by providing what is clinically appropriate in light of the physical, emotional and mental health conditions of the patient. Then, the legal issues surrounding the proposed treatment, including the consent and

confidentiality laws governing their actions, must be carefully weighed. Also, doctors must encourage communication between teenagers and parents while guaranteeing confidential care to their adolescent patients.

An excessive workload and previous training may have an effect on doctors' behaviour regarding confidentiality, but this cannot be firmly established from the results obtained and more studies are needed.

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Authors' affiliations

M D Pérez-Cárceles, E Osuna, A Luna, Department of Legal and Forensic Medicine, School of Medicine, University of Murcia, Murcia, Spain

J E Pereñíguez, Health Center in Espinardo, Murcia

D Pérez-Flores, Department of Biostatistics, School of Medicine, University of Murcia, Murcia

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