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Adolescents, contraception, and confidentiality: a national survey of obstetrician-gynecologists

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Abstract

Background—Given recent legislative efforts to require parental notification for the provision of reproductive health care to minors, we sought to assess how ob/gyns respond to requests for confidential contraceptive services.

Study Design—Mailed survey of 1800 U.S. Obstetrician-Gynecologists, utilizing a vignette where a 17-year-old college freshman requests birth control pills and does not want her parents to know. Criterion variables were the likelihood of: encouraging her to abstain from sexual activity until she is older; persuading her to involve her parents in this decision; and prescribing contraceptives without notifying her parents. Covariates included physicians' religious, demographic, and clinical characteristics.

Results—Response rate 66%. Most (94%) would provide contraceptives without notifying her parents. Half (47%) would encourage her to involve a parent, and half (54%) would advise abstinence until she is older. Physicians who frequently attend religious services were more likely to encourage her to involve her parents (OR 1.9), and to abstain from sex until she is older (OR 4.4), but equally likely to provide the contraceptives.

Conclusions—Most obstetrician-gynecologists will provide adolescents with contraceptives without notifying their parents.

Keywords

contraception; confidentiality; directive counseling; ethics; religion

1. Introduction

Adolescents are a unique patient population. They are transitioning toward independence without having fully attained it. When teenagers request sexual and reproductive health care,

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and do not want their parents to know, physicians may face difficult questions about what advice to offer, and whether to promise confidentiality [1].

The medical profession generally supports maintaining confidentiality in the care of adolescents [1,2]. The Society for Adolescent Medicine calls it “essential” [3], the American Medical Association calls it “critical” [4], and the American College of Obstetricians and Gynecologists (ACOG) considers its absence “a major obstacle to the delivery of health care to adolescents” [5]. Proponents argue that parental notification would dissuade adolescents from utilizing sexual health services, and increase their risk of pregnancy or infection [3,6–8]. A number of court decisions and state laws have supported the provision of confidential sexual health services to minors [2,9,10], and confidentiality is mandated for all US clinics receiving Title X funding [3,9,10].

Yet parents (or guardians) have a legitimate interest in knowing what is happening in their child’s life. The US Conference of Catholic Bishops, considers Title X’s lack of parental notification to be an affront to parents’ rightful role [11]. Adolescents who engage in experimentation and risk-taking (e.g., unprotected sex, concurrent sexual partners) may not be ready to take full responsibility for important health decisions [2,5,12]. Several bills have even been proposed in recent years that would require parental notification or otherwise limit confidentiality [1,7,10,13]. Thus while it may be standard for physicians to promise confidentiality to minors, it is a contested standard.

Less clarity exists regarding what sort of counsel physicians should offer adolescents regarding their sexual activity. Given adolescents’ growing autonomy, some advocate focusing on patient education; providing information about abstinence and safer sex in a nondirective manner [14]. However, adolescents’ immature decision-making capabilities, the potential high stakes of sexual activity, and the physician’s place as perhaps the only trusted adult influence on the patient’s sexual decisions support more directive counseling.

These ambiguities are longstanding, yet little is known about how physicians respond to requests for confidential sexual and reproductive health services. Prior studies have focused instead on what patients [1,6,13] and parents believe [7] and what services are available for adolescents [15,16]. We surveyed a nationally representative sample of Obstetrician-Gynecologist (Ob/Gyn) physicians, asking them whether they would confidentially provide birth control pills to a 17-year-old college freshman, and how they would counsel the patient. We measured a number of physician characteristics, including religious characteristics, because sexuality and contraception involve religious and other moral commitments, and because religious commitments influence physicians’ practices [17,18].

2. Materials and methods

From October 2008 until January 2009, we mailed a confidential self-administered questionnaire to a stratified random sample consisting of 1800 US general Ob/Gyn physicians 65 years old or younger. The sample was generated from the American Medical Association Physician Masterfile, a database intended to include all practicing US physicians. To increase minority representation (especially minority religious perspectives), we used validated surname lists to create four strata [19–21]. We then sampled: a) 180 physicians with typical south Asian surnames; b) 225 physicians with typical Arabic surnames; c) 180 physicians with typical Jewish surnames; and d) 1215 other physicians (from all those whose surnames were not on one of these ethnic lists). Physicians received up to three separate mailings of the questionnaire; the first included a \$20 bill, and the third offered an additional \$30 for participating. Physicians also received an advance letter and a postcard reminder after the first questionnaire mailing. All data were double-keyed, cross-

compared, and corrected against the original questionnaire. The study was approved by the University of Chicago institutional review board.

2.1. Questionnaire

Primary criterion measures assessed physician responses to a vignette where a 17-year-old college freshman presents seeking birth control pills, but does not want her parents to know. We asked physicians how likely they would be: 1) to encourage her to abstain from sexual activity until she is older; 2) to try and persuade her to involve one or both of her parents in this decision; and 3) to prescribe contraceptives without notifying her parents. The four response options ranged from “not at all likely” to “very likely”. When developing the questionnaire, we selected a 17-year-old freshman to examine a scenario that is especially challenging for physicians, because 17-year-olds are clearly minors but are almost legal adults, and because most college freshman are living outside of their parents’ home for the first time (a period of greater independence and also greater vulnerability). We iteratively revised the vignette after expert review and cognitive pretesting to ensure face validity and to minimize social-desirability bias.

Covariates included religious characteristics. Religious affiliation was classified as none/no affiliation, Hindu, Jewish, Muslim, Catholic (includes Roman Catholic $n=237$, and Eastern Orthodox $n=25$), Evangelical Protestant, non-Evangelical Protestant, and other religion (includes 9 Buddhists). Respondents’ beliefs about religion’s importance ranged from ‘not very important in my life’ to ‘the most important part of my life.’ Attendance at religious services was categorized as never, once a month or less, and twice a month or more.

Additional covariates included demographic characteristics (gender, age, race, region, and immigration history) and clinical characteristics (board certification, ACOG membership, working primarily in an academic medical center, percentage of patients under 18-years-old). We also compared physicians who are parents with those who are not.

2.2. Statistical analysis

Case weights were incorporated to account for the oversampling strategy (the design weight), and to correct for differences in response rate among the surname categories and between US versus foreign medical school graduates (the post-stratification adjustment weight). Weights were the inverse probability of a person with the relevant characteristic being in the final dataset. The final weight for each case/respondent was the product of the design weight and the post-stratification adjustment weight. This method of case weighting – widely used in population-based research [22] – enabled us to adjust for sample stratification and variable response rates in order to generate estimates for the population of U.S. Ob/Gyns. We used the chi-square test to examine the associations between each background variable and physicians’ responses to the patient scenario. We then conducted multivariable logistic regression using physicians’ sex, race, immigration history, board certification status, age, and geographic region as covariates. All analyses were conducted using the survey-design-adjusted commands of Stata SE statistical software (version 10.0; Stata Corp., College Station, TX).

3. Results

The response rate was 66% (1154/1760) after excluding 40 potential respondents who were retired or who could not be located after two attempts to obtain a valid address. The response rate varied by sample; 68% (807/1188) of the primary sample responded, 54% (120/221) of those with Arabic surnames responded, 61% (107/175) of those with South Asian surnames responded, and 68% (120/176) of those with Jewish surnames responded.

Graduates of foreign medical schools were less likely to respond than graduates of US medical schools (58% vs. 68%, $p=0.001$). Response did not differ significantly by age, gender, region, or board certification. Respondents' demographic characteristics are reported in Table 1.

When encountering a 17-year-old college freshman who is requesting oral contraceptives but does not want her parents to know, physicians were divided on whether to counsel her to abstain from sexual activity until she was older, with 54% being somewhat or very likely to offer this counsel. Physicians were also divided on whether to try and persuade the patient to involve one or both parents, with 47% being somewhat or very likely to advise this. However, most physicians would provide the contraceptive pills without notifying her parents (84% very likely, 11% somewhat likely) (Table 2).

Physicians' religious characteristics were associated with advising the patient to abstain from sex until she is older. Doctors with any religious affiliation (except Jewish) were more likely than unaffiliated doctors to advise abstinence. For example, compared with unaffiliated doctors, Evangelical Protestants were more likely to advise abstinence (76% vs. 31%, OR 7.0, 95%CI 3.7–14). Intensity of religious beliefs was also significant. Doctors who consider religion the most important part of their lives were more likely to advise abstinence than those who consider religion not very important (81% vs. 32%, OR 8.9, 95%CI 5.2–15). Additionally doctors who attend services twice a month or more were more likely to advise abstinence than doctors who never attend services (68% vs. 32%, OR 4.4, 95%CI 2.7–7.2) (Table 3).

Religious physicians were also more likely to advise involving a parent. Evangelical Protestants were more likely than unaffiliated doctors to advocate parental involvement (54% vs. 37%, OR 2.0, 95%CI 1.1–3.7). Doctors who consider religion the most important part of their lives were more likely to persuade her to involve a parent than those who consider religion unimportant (57% vs. 38%, OR 2.2, 95%CI 1.4–3.4). Also, those who attend services twice a month were more likely to advise involving a parent than those who never attend services (53% vs. 37%, OR 1.9, 95%CI 1.2–3.1) (Table 3). Importantly, there was no significant association between physicians' religious characteristics and the likelihood of providing birth control pills confidentially. (Dichotomizing the variable at "very likely" versus "other responses" did not yield significant associations either.)

In multivariable logistic regression including all religious and demographic characteristics as covariates, we found that, compared with doctors in the South, doctors were less likely to advise abstinence if they were located in the Northeast (45% vs. 59%, OR 0.6, 95%CI 0.4–1.0) or in the West (44% vs. 59%, OR 0.6, 95%CI 0.4–1.0). Males were less likely to provide contraceptives without parental notification (91% vs. 97% of females, OR 0.2, 95%CI 0.1–0.5). Physicians who see more minors (10% or more of their patients are under 18 years of age) were more likely to persuade the patient to involve her parents (50% vs. 42%, OR 1.4, 95%CI 1.0–1.8). Physicians who were parents themselves were more likely to advise the patient to abstain from sex until she is older (55% vs. 42% of non-parents, OR 1.9, 95%CI 1.2–3.1). Physicians' decisions were not associated with ACOG membership (Table 4).

4. Discussion

In this national representative survey, we found that the great majority of Ob/Gyn physicians (94%) are somewhat or very likely to provide birth control pills to a 17-year-old college freshman without notifying her parents. At the same time, half (47%) would encourage her to involve a parent, and half (54%) would advise her to abstain from sexual activity until she

is older. Physicians who are more religious are more likely to encourage her to involve her parents, and are more likely to advise her to abstain from sex until she is older, but they are equally likely to provide contraceptives in the end.

Ob/Gyn physicians' willingness to provide birth control pills to the patient in this case is higher than has been reported for other physicians. Regional data from 1998–1999 suggested that 83% of pediatricians, 85% of family medicine doctors, and 63% of internal medicine doctors provide contraceptive services without parental knowledge [15]. However, some are unlikely to view this result as progress. Ross [12] has questioned whether this widespread policy of confidentially supplying contraceptives to adolescents involves physicians in collusion against parents, undervalues parents' conceptions of the good, and underappreciates adolescents' need for parental guidance.

Many factors likely contribute to physicians' willingness to provide contraceptives in this particular vignette. Adolescence is a period of continuously developing maturity and autonomy, such that as patients grow older and more independent, clinicians are more comfortable providing confidential care [3]. The Society for Adolescent Medicine has advised physicians to consider the patient's chronological age, cognitive and psychosocial development, other health-related behaviors, and prior family communication [3] – each of which might support confidentiality in this case. The American Medical Association is even more open, advising that unless the law requires otherwise, physicians should permit a competent minor to consent to sexual and reproductive medical care and should not notify her parents without her consent [4]. Additional considerations that could motivate physicians to provide contraceptives include a belief that access to contraceptives may improve public health [8], or concern that teenagers may not seek contraceptive services if their parents are notified [2,3,10,23]. Moreover, the patient in this vignette may meet some states' criteria for not requiring parental notification, since many states have provisions for some minors (e.g., mature minors, emancipated minors, military personnel, or those living independently) to consent for contraceptive services [3,5,10].

Physicians varied markedly regarding whether they would encourage the patient to involve her parents in the decision, with 47% very likely or somewhat likely to try and persuade her to involve a parent. It is worth noting that many guidelines encourage physicians to persuade adolescents to involve their parents. The American Medical Association says that, “when minors request confidential services, physicians should encourage them to involve their parents” [4]. ACOG holds that “providers should encourage and, when appropriate, facilitate communication between a minor and her parent” [5]. Similarly, the Society for Adolescent Medicine states that health care professionals should support (but not mandate) effective communication between adolescents and parents; “helping adolescents to see the potential advantages of increased communication with parents, and offering to facilitate communication with parents in a way that is helpful to the adolescent patient” (p. 162) [3]. It is possible that physicians who treat adolescents more frequently have greater familiarity and comfort with these guidelines, so are slightly more likely to encourage patients to involve their parents. Even so, that only half of Ob/Gyn physicians would take this approach suggests there is room for reminding physicians that encouraging adolescents to involve their parents is well within professional guidelines.

Roughly half (54%) of Ob/Gyns would advise a 17-year-old patient to abstain from sexual activity until she is older. This is a lower percentage than was found in a 2003 survey of family planning directors at publicly funded family planning clinics, among whom 91% provide routine counseling about abstinence to patients 17 years old and younger during an initial contraceptive visit, and 77% provide abstinence counseling to 18–19 year olds [16]. This suggests that routine counseling may introduce the concept of abstinence without

necessarily promoting it. Pragmatically though, 91% of minors attending publicly funded family planning clinics were already sexually active, and had been active for an average of 20 months (2004 data) [6], making abstinence a tough sell and perhaps prompting physicians to focus their efforts on sex education and safety.

Religious physicians were more likely to advise abstinence, a trend that is consistent with other literature linking religiosity with the belief that sex should be limited to marriage [24–28]. It is possible that religious physicians have a higher percentage of religious patients, and to advise abstinence is to reinforce a value the patient already holds. Alternatively, religious physicians may emphasize best-interest over autonomy-based decision-making paradigms in morally complex situations [18].

Advising patients to practice abstinence is somewhat at odds with the clinical model promoted by McCullough and Chervenak [14]. They recommend that when a patient wants to be sexually active, her decision must be respected, and the physician should explain the techniques of safer sex; in a nondirective fashion (p. 174–5 [14]). But while this may be standard practice for adult patients, minors are different. Developmentally, socially, and legally minors do not have the same decisional rights and capabilities as adults. Moreover, teenagers are rarely able to take full responsibility if their sexual activity leads to infection or unplanned pregnancy (they rarely pay their own health care bills, and few can raise a child without help from social services). The trends in our data suggest that while physicians recognize adolescents' emerging autonomy, many believe it is important to offer guidance and direction too.

Our data reveal that physicians who are themselves parents are more likely to advise abstinence to a seventeen year old. Few would deny that the experience of raising a child invites persons to reconsider a number of beliefs. However the findings are unique in suggesting that the experience of parenthood shapes the clinical care physicians provide to adolescents.

A strength of this study is its nationally representative sample. Several prior national studies focused on publicly funded family planning clinics [1,13,16]. However, these clinics provide services for only a minority of women (17% in one survey) [29]. Additionally, patient populations at government funded family planning clinics do not match the general population, with publicly funded clinics seeing higher percentages of younger, unmarried, minority, less educated, and less insured women compared with private physicians or Health Maintenance Organizations [6,29]. Another strength is the high response rate.

Limitations of the study include its dependence on self-report, which may differ from actual practice. Non-responders may differ from responders in ways that bias the results. The vignette involved a 17-year-old college freshman, so we cannot apply the findings to minors in general. Future research directions might include using more vignettes to examine which patient characteristics influence physicians' decisions the most, conducting qualitative studies to examine whether some counseling techniques are better received than others, and measuring outcomes to determine when counseling is likely to be effective.

In conclusion, this national survey of Ob/Gyn physicians indicates that the vast majority are willing to provide confidential birth control prescriptions to minors in at least some circumstances. Religious physicians are more likely to advise such patients to involve their parents and to delay sexual activity until they are older, but are equally likely to provide contraceptives in the end. While physicians and teenagers should still discuss confidentiality, older adolescents can anticipate that the great majority of Ob/Gyn physicians will provide them contraceptives without notifying their parents.

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Table 1

Respondent demographics

	N	% ^a
Sex		
Female	537	47
Male	617	53
Race		
White, non-Hispanic	774	69
Black, non-Hispanic	67	6
Asian	202	18
Hispanic/Latino	64	6
Other	22	2
Age, years		
25–40	291	25
41–47	305	26
48–55	281	24
56–65	277	24
Region		
South	373	32
Midwest	249	22
Northeast	288	25
West	242	21
Immigration history		
US born	817	72
Immigrated to US	323	28
Education		
US medical school graduate	932	81
Foreign medical school graduate	222	19
Board certification		
Board certified	963	83
Not board certified	191	17
Religious affiliation		
No affiliation	119	11
Hindu	91	8
Jewish	160	14
Muslim	54	5
Catholic/Orthodox	262	23
Evangelical Protestant	91	8
Non-evangelical Protestant	300	27
Other religion	48	4
Importance of religion		
Not important	272	24

	N	% ^a
Fairly important	321	28
Very important	385	34
Most important	157	14
Attend services		
Never	123	11
Once a month or less	547	48
Twice a month or more	466	41
Personal/Clinical characteristics		
ACOG member	1052	92
Work primarily in academic medical center	305	27
10% or more patients under 18 years old	678	61
Physician is a parent	973	86

^a Percentages are not survey-design adjusted. Results do not sum to 100% due to rounding error. Age: mean 47.8, st dev 9.2, range 26–65.

Table 2

Estimates of US Ob/Gyn physicians' response to a minor requesting confidential access to contraception

Please consider the following case: A 17-year-old college freshman presents to you seeking birth control pills and does not want her parents to know. How likely would you be to do each of the following:		
	N	%^a
Encourage her to abstain from sexual activity until she is older		
Not at all likely	224	21
Not very likely	302	26
Somewhat likely	288	26
Very likely	318	28
Try to persuade her to involve one or both of her parents in this decision		
Not at all likely	267	23
Not very likely	334	31
Somewhat likely	285	25
Very likely	249	22
Prescribe contraceptives without notifying her parents		
Not at all likely	27	2
Not very likely	47	4
Somewhat likely	121	11
Very likely	950	84

^a Percentages are adjusted for survey design and estimate the percent of all US Ob/Gyn physicians.

Table 3

US Ob/Gyn physicians' responses to a minor seeking confidential access to contraception, by physicians' religious characteristics

	Somewhat/very likely to encourage a 17-year-old to abstain from sex		Somewhat/very likely to persuade a 17-year-old to involve her parents		Somewhat/very likely to prescribe contraceptives without notifying parents	
	N (%) ^a	p ^b	OR (95%CI) ^c	N (%) ^a	p ^b	OR (95%CI) ^c
Affiliation						
No affiliation	37 (31)	<.001	1.0 referent	48 (37)	.2	1.0 referent
Hindu	65 (81)		1.2 (5.2-29)	49 (56)		2.0 (.4-8.7)
Jewish	49 (30)		1.1 (0.6-1.9)	64 (40)		1.0 (.3-3.5)
Muslim	28 (58)		3.6 (1.4-9.3)	25 (54)		.5 (.1-2.1)
Catholic/Orthodox	151 (58)		3.2 (1.9-5.3)	127 (47)		.7 (.2-1.8)
Evangelical Protestant	68 (76)		7.0 (3.7-14)	49 (54)		.6 (.2-1.8)
Non-evang Protestant	160 (54)		2.4 (1.4-3.9)	136 (47)		1.1 (.4-3.4)
Other religion	29 (55)		3.6 (1.6-8.1)	25 (44)		.5 (.1-2.3)
Importance of religion						
Not important	92 (32)	<.001	1.0 referent	105 (38)	.004	1.0 referent
Fairly important	160 (51)		2.0 (1.4-3.0)	153 (48)		.8 (.3-1.9)
Very important	221 (59)		2.8 (2.0-4.1)	179 (46)		.4 (.2-1.0)
Most important	120 (81)		8.9 (5.2-15)	86 (57)		.4 (.1-1.1)
Attendance						
Never	44 (32)	<.001	1.0 referent	49 (37)	<.001	1.0 referent
Once/month or less	243 (44)		1.8 (1.1-2.8)	233 (42)		2.3 (1.0-5.4)
Twice/month or more	306 (68)		4.4 (2.7-7.2)	242 (53)		1.3 (.5-3.1)

^aPercentages are adjusted for survey design and estimate the percent of all US Ob/Gyn physicians.

^bp values reflect the bivariate associations between religious characteristics and responses to a minor seeking confidential access to contraception.

^cResults of multivariable logistic regression; analysis includes sex, race, immigration history, board certification, age, and region.

Table 4

US Ob/Gyn physicians' responses to a minor seeking confidential access to contraception, by physicians' personal and clinical characteristics

	Somewhat/very likely to encourage a 17-year-old to abstain from sex			Somewhat/very likely to persuade a 17-year-old to involve her parents			Somewhat/very likely to prescribe contraceptives without notifying parents		
	N (%) ^a	p ^b	OR (95%CI) ^c	N (%) ^a	p ^b	OR (95%CI) ^c	N (%) ^a	p ^b	OR (95%CI) ^c
ACOG non-member	56 (61)	.2	1.0 referent	47 (51)	.4	1.0 referent	81 (91)	.3	1.0 referent
ACOG member	545 (53)		.7 (.4–1.2)	483 (46)		.8 (.5–1.4)	985 (94)		1.7 (.6–5.0)
Non-academic practice location	448 (55)	.02	1.0 referent	382 (46)	.9	1.0 referent	766 (93)	.02	1.0 referent
Work primarily in academic medical center	147 (47)		.7 (.5–1.0)	143 (46)		1.0 (.8–1.4)	291 (97)		2.2 (1.0–4.7)
<10% of patients under 18 years old	211 (48)	.008	1.0 referent	183 (42)	.01	1.0 referent	418 (95)	.2	1.0 referent
10% or more patients under 18 years old	380 (57)		1.3 (1.0–1.8)	339 (50)		1.4 (1.0–1.8)	624 (93)		.8 (.4–1.5)
Physician has no children	71 (42)	.006	1.0 referent	85 (49)	.4	1.0 referent	154 (95)	.6	1.0 referent
Physician is a parent	521 (55)		1.9 (1.2–3.1)	437 (45)		.8 (.5–1.2)	903 (94)		.9 (.3–2.5)

^aPercentages are adjusted for survey design and estimate the percent of all US Ob/Gyn physicians.

^bp values reflect the bivariate associations between religious characteristics and responses to a minor seeking confidential access to contraception.

^cResults of multivariable logistic regression; analysis includes religious affiliation, importance of religion, attendance at services, sex, race, immigration history, board certification, age, and region.