Teenagers have a right to confidential consultations with GPs

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The Wonca-Europe 2004 meeting in Amsterdam was an extraordinary event. The fascinating mega-workshops on the subject of communication and attitudes were certainly a highlight for all 2500 participants working in groups of five, indeed worth citing in the Guinness Book of Records! For five hours, participants, led by a highly competent team, exchanged, discussed and revised many ideas about current family practice. The general picture was that of European Family Doctors riding on the latest wave of science, technology and communication.

Unfortunately, no picture is perfect. A few areas of non-universally shared knowledge remain in European General Practice. Later during this conference we discovered that one of these was the understanding that teenagers need confidential health services. This is the topic we wish to raise here.

Enthusiasm following the mega-workshops probably benefited the workshop we ran later in the day on communication with adolescents[4]. We chose an interactive design. Following an introduction reviewing the developmental aspects of adolescence (biological, psychological, cognitive and social), we presented a framework for the biopsychosocial interview of teenagers known as the "HEADSS" screen (Table 1). We then proposed case scenarios that allowed participants to practice using the HEADSS screen as a thread to lead consultations with young people.

In one scenario, Sarah, a 16-year-old girl, presents to the general practitioner with urinary symptoms. Her mother accompanies her into the consultation room. Workshop participants were asked to focus the role-play on offering confidentiality and consultation time without the mother in order to ask Sarah about her sexual activity.

Whereas no participant felt uneasy using the HEADSS framework in the role-play, many questioned the need for consultation time with the teenager alone. They explained that in their practice they had never considered asking the parent to leave the consultation room before. Reticence to engage in this aspect of the role-play only dropped when we revealed that in our fictitious scenario Sarah was in fact pregnant, and unwilling to disclose this fact to the doctor if her mother was present.

Table 1. HEADSS framework for the psychosocial interview of teenagers (from Goldenring [1]).

Home (current living situation)
Education and employment, Eating habits
Activity (sports and leisure)
Drugs (use and misuse tobacco, alcohol, illegal drugs)
Sexuality (identity, expectations, behaviour)
Suicide (mood, anxiety, depression, suicidal conduct)

There is no defined age from which teenagers should be offered confidential consultation time. In practice, confidentiality should, ad minima, be offered to adolescents who are mature enough to consent to a treatment on their own. The age limit for such maturity is not generally defined by law. Rather, it is up to practitioners to assess whether a teenage patient is mature enough to understand the consequences of these choices. Research shows that from the age of about 14, teenagers increasingly acquire the cognitive ability to make treatment decisions on their own [3]. Providing a family doctor uses tact in his/her explanation to parents, it is rare that they object to letting their teenage child spend part of the consultation alone with the doctor. In the box, we present an example of how this can be done.

Case scenario[5]

You know Sarah's mother, who comes to see you regularly in the practice, but you have not met Sarah before, since she usually sees the paediatrician. As you go and meet Sarah and her mother in the waiting room, you greet Sarah first and intro-

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4 Contents of this workshop were based on the EuTEACH Programme (European Training in Effective Adolescent Care and Health: www.euteach.com), and on training material developed by the Centre for Adolescent Health in Melbourne, Australia and by Dr Chris Donovan, Royal College of GP, UK.
5 Inspired from the video "Clueless: Trigger tape for Primary Care Teams", by Dr C. Donovan, UK.

duce yourself to her. While you are still in the waiting room, you explain to Sarah and her mother that you usually see teenagers on their own, but you welcome parents' presence at the beginning of the consultation, so that they may express any concerns they have about their child's health.
In your consultation room, you start by explaining that Sarah's consultation will be confidential: you will not reveal the content of the consultation to anyone not even her mother without Sarah's consent. You remember to state the three exceptions to this rule: situations in which you would have to inform another person in order to keep Sarah safe, such as if she revealed she planned to kill herself, or kill someone else, or if she was victim of abuse. You then ask Sarah to explain the motive of her consultation and offer her mother the opportunity to voice her concerns. The mother tells you she thinks her daughter has cystitis. Once the mother has told you her side of the story, you ask her to step out of the room. She is happy to do so, since you presented the schedule of the consultation clearly to her from the start.
Using the HEADSS screen as a lead, you find out that Sarah is worried her happy life at home might change soon. She is doing fine in school and tells you she really enjoys biology (it is important to note this as it may act as a protective factor). She has not been eating so well lately because she often feels nauseous. She mentions she likes going out at week-ends but has occasionally had regrets about going to certain parties. Reluctantly, and because you insist that what she says can remain confidential, she tells you she regrets one particular night when she abused alcohol and cannabis. She says that without it she would not be "in this mess" now. You acknowledge that substances may lead some people to lose control, which leads her to tell you that this is how she has become pregnant.
You reiterate your promise of confidentiality but underline that it would be best to tell her mother. You offer your help in disclosing this news to her. As Sarah remains reluctant to do so, you propose she takes a day or two to think about it, and reflect on the options you have just explained to her regarding the future of this pregnancy. Before you invite her mother back in, you check that Sarah is not so distressed as to have suicidal ideas. You then explain to Sarah that you cannot lie to her mother but that you can prepare with her "how much" to tell her. Since you do need to exclude a urinary tract infection, and to confirm the pregnancy you agree with Sarah that you will tell her mother that Sarah's symptoms may be due to an infection but that tests need to be done before treatment can be installed. Before the consultation ends, you remember to ask Sarah for her mobile phone number so that you may call her (or send an SMS) if the results show she needs to come back sooner than for her next appointment in three days.

By offering confidential consultation time to teenage patients, family doctors can uncover the real health issues and offer the appropriate management. The doctor should also try to help teenagers in their relationship to their parents and assist them in disclosure of the true situation to them.
In many countries, teenagers have the legal right to consult and consent to treatment on their own [2, 3]. Yet, often, concerns about confidentiality are at the top of young people's list of barriers in accessing health services [2, 4]. As family doctors, we have an important role to play in responding to young people's health needs by providing adolescent-friendly services, ie, services that are accessible, affordable and developmentally appropriate [5]. Offering confidentiality is a priority step in responding to the needs of adolescents who come into our practices.

References

1 Goldenring JM, Cohen E. Getting into adolescents heads. Contemporary Pediatrics 1988:75–90.
2 Milne AC, Chesson R. Health services can be cool: partnership with adolescents in primary care. Family Practice 2000;17:305–8.
3 Sanci LA, Sawyer SM, Weller PJ, Bond LM, Patton GC. Youth health research ethics: time for a mature-minor clause? Med J Aust 2004;180:336–8.
4 Booth ML, Bernard D, Quine S, Kang MS, Usherwood T, Alperstein G, et al. Access to health care among Australian adolescents: young people's perspectives and their socio-demographic distribution. J Adolesc Health 2004;34:97–103.
5 World Health Organisation. Adolescent Friendly Services: an agenda for change. Geneva: WHO; 2002.

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