

# Attitudes of family doctors, attached to the Department of Family Medicine, towards consulting and treating young people

Pierre Mallia, Bridget Ellul, Jurgen Abela

## Abstract

**Background:** There is a perceived concern that there is no law which governs the right of young people (YP), defined as ages 15-18, to be treated by doctors and to have their privacy protected from their parents or legal guardians. On the other hand doctors seem not to be covered by a specific law which allows them to see and treat this age group, although the Medical Council has expressed itself once in this regard.

**Method:** This study aimed to assess the perception of doctors to seeing young adults alone since they are considered vulnerable because of their age and may not express concerns and practices if in front of parents or guardians. In this regard a questionnaire was delivered to family doctors attached with the department of family medicine at the University of Malta.

## Keywords

Young people, confidentiality, privacy, vulnerability, law, 'Gillick competence'

**Results:** the response rate was 72.5%. Most respondents were males. Most (89.6%) agreed that YP have a right to speak to the family doctor alone. Doctors are happy to discuss various topics with YP alone, but in certain issues, find difficulty in providing treatment to YP alone. There seems to be a significant difference in attitude towards the sex of the doctor with respect to the sex of the patient.

**Conclusion:** The study was meant to be a pilot study including those doctors attached to the Department of Family Medicine at the Medical School, with a future study planned on a larger number. The significance and importance of the results however merited previous publication of this study as a sentinel. Doctors are largely concerned about the law and are sometimes reluctant to see young adults alone even if they feel that they should be able to do so. The importance of having a clarification of the law by an amendment is discussed.

## Introduction

Teenagers rate confidentiality as one of the most important factors in the doctor-patient relationship and in their medical care.<sup>1</sup> The core competencies of family medicine include *primary care management, a person-centred approach, specific problem solving skills, community orientation, comprehensive management, and a holistic approach to care.*<sup>2</sup> Young People (YP) are people between the ages of 15-18 years.<sup>3</sup> When it comes to YP these core competencies can be jeopardized if legislation does not allow this age group to consult their family doctor without a guarantee of confidentiality, and to be treated without the knowledge of parents. It is unlikely that this age group will speak to the doctor about sensitive issues such as drug-related and sexually-related problems, unless they are alone, as admitting to certain behaviors in front of parents is unlikely as their autonomy (and respect for this principle thereof) is compromised by the controlling influence which a parent can still have psychologically at that age. Such problems can, and should be treated, and counsel given early. Moreover it is known that such problems can be associated with psychiatric conditions, which again should be managed early on.<sup>4</sup> The doctor-patient relationship is a fiduciary relationship; it is based on trust. This trust can be compromised if confidentiality and

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respect for autonomy are not guaranteed<sup>5</sup> leading to a likely state where young adults do not seek help. Although parents and other institutions can help identify and establish contact with YP,<sup>6</sup> identifying the risk and protective factors (such as familial environment and peer pressure)<sup>7</sup> can be difficult if the fiduciary nature of the relationship is not established immediately.<sup>8</sup> The European Standards on Confidentiality and Privacy in healthcare identify YP as a vulnerable group “because of assumptions made simply on the grounds of chronological age about their ability to make competent decisions”, and that “explicit attention to the vulnerability of a person encourages better practice and ethical engagement with them, regardless of the ethical views or values of the healthcare professional or of the patient. Awareness of vulnerability avoids unwarranted assumptions being made about the status of decision-making processes where there are significant power differences.”<sup>6</sup>

In the UK, legally, adolescents have the right to make decisions for themselves depending on their competence, defined as the cognitive ability, rationality, self-identity, and ability to reason hypothetically.<sup>1</sup> The obligation to respect the rights of adolescents, “irrespective of their ability to make decisions for themselves, provided that to respect these rights does not result in harm to the adolescent or to others” is an ethical duty laid down in the UN Convention of the Rights of the Child.<sup>1</sup> Nevertheless considerable confusion exists with respect to the moral appropriateness and legality of teenagers seeking contraception advice, treatment of venereal disease and in some countries, abortion services. Unless confidentiality is guaranteed they may not seek the appropriate care they need; conversely they may not get the parental counseling and support they need.<sup>8</sup> This must be balanced against the pressures YP face even when with friends. The General Practitioner is strategically placed, once confidentiality is protected, to provide counsel at the most important stages. When it comes to contraception, teenagers are often confused about where they can obtain contraceptive advice.<sup>9</sup> A recent study in the *Lancet* shows that risky sexual behaviour has led to a dramatic increase in sexually transmitted infections.<sup>10</sup> Such increase has also been noted locally. Whilst in the UK, the law still defines anyone under 18 years as a minor, older minors over 16 years are given more autonomy and if they have capacity they can legally consent to medical procedures.<sup>11</sup> Though a child under 16 years of age may be ‘Gillick competent’<sup>12</sup> and so can legally consent, it is still advisable for a GP to see someone under this age with a responsible adult with them, even though the latter may be asked not to be present throughout the consultation.<sup>13</sup> Indeed if the minors are ‘Gillick competent’, general practitioners still have a duty to respond as best they can for the wellbeing of the child, even ensuring confidentiality and providing treatment.<sup>13</sup> Orme et al<sup>13</sup> argue that the fact that the law permits this, it does not make it any easier sometimes for the general practitioner to decide how far confidentiality actually is, and if always, in the best interests of the child. UK legislation still allows parents to override refusal of consent by 16-18 year olds, but a general

practitioner may again be reluctant to provide treatment to older minors who are competent and still refuse, unless this is emergency treatment.

Nevertheless many Family Medicine texts do advocate that whilst trying to encourage teenagers to involve their parents, family doctors do have a duty to see YP alone<sup>14,15</sup> and a duty as patient advocates to encourage necessary changes to the law to enable such interactions.<sup>5</sup> Whilst it is understandable that parents who are interested and care for the child and their problems have a need to know, that such information sharing may be beneficial does not diminish the duty of confidentiality.<sup>5</sup>

## Methods

Malta has a dual system of private family doctors, and state health care centres, where primary care is provided. Medical students undergo clinical attachments with some general practitioners working in both systems during the course of their studies within the Department of Family Medicine at the Medical School of the University of Malta. As a pilot to this study the questionnaire was sent to these (forty) doctors as they provide a unique cohort of doctors involved in the training of undergraduate students and it was felt that their response is significant with regard to the development of future generation of doctors. The questionnaire was intended to be validated through this cohort. However the significant results, along with the current pressure to introduce legislation for confidentiality and treatment of young adults induced the authors to publish the results. The questionnaire was divided into two sections; the first dealing with demography and the second containing ten questions. Demographic details included whether the doctor works in a health centre, in private practice or both, in order to evaluate any differences in management of this age group in private practice and at the health centres. Doctors working both privately and in health centres had to mark if they handled this age group differently in health centres than in their private practice. The doctors were divided into male and female to assess whether the sex of the doctor made a difference to seeing either of the two sexes of the age group being studied. Doctors were also divided into age groups to analyze whether their views changed with respect to age.

The second part of the study asked questions relating to how comfortable a doctor was in seeing YP in the absence of parents; whether they felt that YP would discuss drug and sexually related issues in front of parents; whether they would break confidentiality in the event they saw the patient; and whether they would always encourage them to speak to their parents. There were two questions relating to perception of the law and two questions which provided a list of disorders/problems, one asking whether they would *treat* these disorders, the other asking whether they would (at

least) *discuss* the problems; in both instances when unaccompanied by adults. There was one question asking whether they would make any exception, should they feel uncomfortable seeing YP, in cases of suspected domestic violence or abuse. The choice of topics put forward was informed by the literature but was also purposefully selected by the authors for perceived difficulty in managing particular clinical situations e.g. sexual practices and YP.

**Results**

The questionnaire to evaluate attitudes towards YP was distributed to 40 professionals. 29 questionnaires were returned in time, giving a response rate of 72.5%. The demographic characteristics of the respondents are summarized in Figure 1. Of the 29 doctors who responded to the questionnaire, there was a predominance of doctors working exclusively in the private sector ( $n=17$ ), whilst there was a paucity of doctors working exclusively in the health centres ( $n=4$ ). Further details in relation to workplace and age are found in Figure 2.

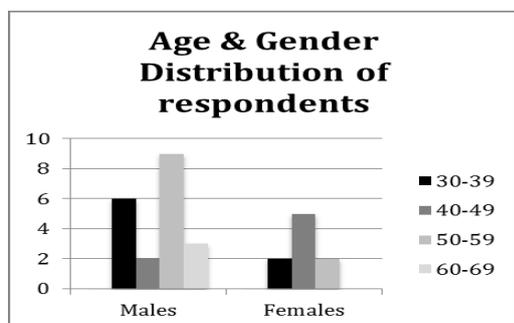


Figure 1 - Age and Gender Distribution of Respondents

The first question of the questionnaire dealt with whether doctors were comfortable seeing YP in the absence of their parents. There was a slight difference in response depending on whether the patient was male or female. In fact, whereas 13 doctors (44.8%) felt comfortable seeing male YP alone, only 11 (37.9%) doctors felt comfortable seeing female YP alone. When asked about discussions in front of parents, many doctors admitted that most probably sensitive

discussion by YP will not be carried out in front of parents. In fact, 23 doctors (79.3%) stated that YP will not discuss sexual matters in front of parents and 24 doctors (82.7%) stated that YP will not discuss drug related problems in front of their parents. Twenty six doctors (89.6%) agreed that YP have a right to speak with doctors alone. Interestingly, of these 26 doctors, 7 stated that they would tell the parents that YP attended as opposed to the remaining 19 who stated that they would not tell the parents that their children had visited the doctor. However, just over half of the 26 doctors ( $n=14$ ) would encourage them always to inform their parents. Of these 26 doctors, 20 of them would be ready to see YP alone in suspected domestic violence. The 3 doctors who stated that YP have no right to speak with doctors alone, were consistent in that they answered question 6 also as negative and question 4 as positive.

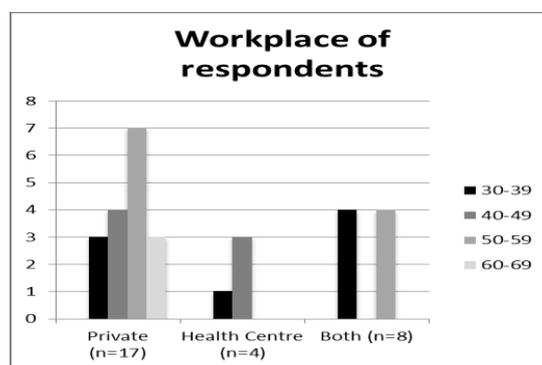


Figure 2 - Workplace of Respondents

One question tested the awareness of the local medical ethical conduct and the law with regard to YP. The results have not been assessed since the question was poorly designed and was not able to discriminate between responses. On a more clinical theme, respondents were asked whether they would provide treatment in certain specific situations and whether they would discuss issues in certain specific situations. In both questions, the YP would be unaccompanied. The results are summarized in Figures 3 and 4.

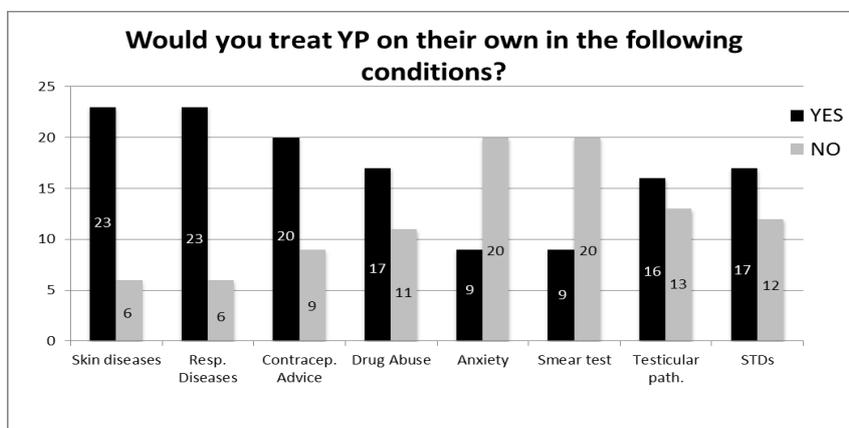


Figure 3 - Treating YP for Specific conditions

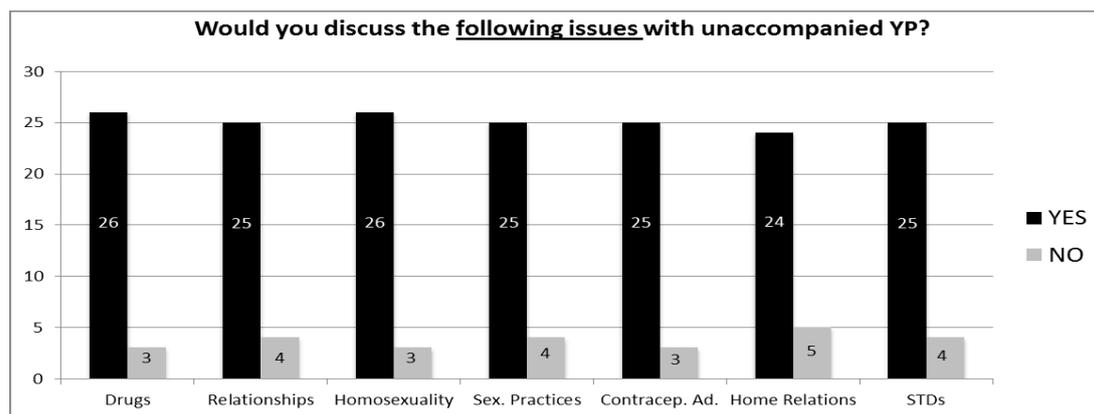


Figure 4 - Discussing issues with unaccompanied YP in specific situations

Finally, respondents were asked whether they think that YP have a right to privacy, truth and confidentiality about their condition. The response, grouped by gender of the respondents is found in Figure 5. Responses were cross-tabulated using 2x2 contingency tables and using Chi Squared tests (with Yates correction), statistically significant responses were identified. Statistically significant relations were found between agreement with the right to privacy and a negative response to telling parents that YP attended ( $p=0.009$ ); between agreeing to the right of privacy and agreeing with the right of YP to speak alone with doctors ( $p=0.0047$ ); and between agreeing to the right to privacy and feeling comfortable seeing male YP alone ( $p=0.04$ ). No other statistically significant results were identified.

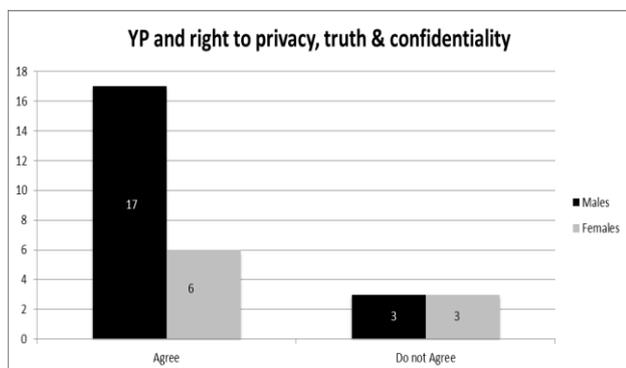


Figure 5 Right to privacy, truth & confidentiality of young people

## Discussion

Counseling to prevent tobacco, alcohol and drug use and to prevent sexually transmitted infections are considered important amongst adolescents; although effectiveness remains unknown, the potential to change behaviour remains valid.<sup>15</sup> In the United States, there were increasing initiatives, especially through “conservative religious groups” to require parental consent or notification for issues related to sexuality, particularly birth control and abortion.<sup>14</sup> The same author argues that careful analysis of such legislation in those states where it had been enforced, had not had any beneficial effect on family communication and that a change in the law did not translate into a change in attitudes; instead a delay or

avoidance of care or a decision to seek clandestine help were noted. “The major documented effects of such legislation are delay in timely diagnosis and treatment and increased medical risk”, and that those of 14 years and over are as competent as adults to make their own choices about reproductive health care.

The General Medical Council in the UK has issued guidance for doctors for the 0 – 18 age group.<sup>16</sup> Whilst allowing for a conscientious objection, providing a safeguard and an explanation is given to the patient, it recommends that YP between the ages of 15-18 years can act autonomously and that the doctor must decide about competence. Moreover it also advises that “when treating children and young people, doctors must also consider parents and others close to them; but their patient must be the doctor’s first concern.”

In Malta there is no legislation regarding the doctor patient relationship and consent for medical procedures, neither for adults nor for children but since locally doctors often follow UK practice guidelines, this guideline has been recommended to the Medical Council of Malta and the approval and amendments to legislation are eagerly awaited.<sup>17</sup> There is however one specific legal provision in the *Mental Health Act, article 3(2)* with regard to health in YP - a minor over 16 years, who is competent to consent, has the legal right to voluntary admission to a mental hospital “notwithstanding any right of custody or control vested by law in his parent or tutor”.<sup>18</sup> Moreover in recent years legislation has been more favourable to defining a child as a person under the age of 16 years, for example in the *Child Abduction and Custody Act, article 2*.<sup>19</sup>

It is also current practice to examine YP over 16 in the genitourinary clinic even when unaccompanied by a parent. Similar practice is slowly being introduced in other hospital clinics, in effect with doctors assessing competence of the minor concerned. This would seem to be an interpretation of the law by the Medical Council of Malta following a letter by the doctor-in-chief at the Genito-urinary clinic; what is important is owed to the urgency of the case rather than age.<sup>20</sup> In our study General Practitioners clearly respect very much the right to privacy of YP. However, it transpires that due to the

lack of clear guidance, a rather differential approach to the management of YP is used. For example, a statistical significant association was found between privacy and the male gender of the patient and there is a clear variation of practice depending on the perceived 'sensitivity' of topic being covered (Figure 3 and 4). Further to this, the fact that doctors, to a greater or lesser extent feel obliged to inform parents might be seen as a breach of confidentiality if one considers YP as a stand alone independent unit, able to carry out informed decision making.

Amongst the limitation of the study one should mention the small cohort selected, even though for an explained reason. A wider study of Maltese family doctors need not reflect the same result since the doctors, not being academically attached, may not be as informed about the legal rights and duties of doctors, although this may not be excluded either. The study therefore can only be extrapolated with caution. A particular strength is that change in law requires academic studies and back-up and the fact that the participants were all attached to the teaching of family practice presents the legislator with an elite group of General practitioners who are concerned also about the teaching that they impart to undergraduate and post-graduate students.

### Conclusion

This is the first time that local doctors were asked about their attitudes towards YP. Although the study was limited to doctors who are involved in training of undergraduate students in their practice, and therefore may contain only the opinion of a select cohort of doctors, which may not be representative of the wider group of doctors practicing in primary care, the results show a significant concern about legislation and that in general doctors would welcome the ability to consult this age group with the backing of legislation. Although the study is limited by the tool not having been validated, the objective of the pilot study was to assess validity and reliability.

In a recent article in the British Journal of General Practice<sup>21</sup> the author asks what message we are sending to young adults when they are not encouraged to see their doctor independently of their parents. The author recommends four challenges to be overcome: creation of a framework which encourages young adults to be responsible for their own health and to be independent users of health care; acknowledgement that no single model may apply to all young people and that their competence and capability to make decisions always needs to be evaluated; acknowledgement that family doctors may need more cultivation of communication skills with young adults; and, learning how to manage the parents during this process.

Young adults need someone, especially during this time of their life and the United Nations International Year of Youth encourages all sectors of society to better understand the needs and concerns of youths.<sup>21</sup> To this effect, efforts are ongoing by the authors to effect changes to local legislation in this regard.

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