Confidentiality for adolescents in the patient/physician relationship

As health care providers for children, we interact with and give information about a child's health to the parents or guardian of that child. As a child gets older we relate more to the child and less to the caregivers, although the latter continue to play an important role in the child's life and are frequently present at the visit to the physician.

Adolescence involves cognitive and psychological changes that prepare a person to assume an adult role. These changes include a move from concrete to abstract thinking, the development of autonomy and the formation of an individual identity. These changes influence the patient/physician interaction, moving it towards a more cooperative relationship. One result is that the teen is encouraged to take more responsibility for his or her own health. This evolving relationship provides the teen with a model of an adult way of interacting and may influence relationships with teachers, coaches and peers.

An important feature of the physician/adolescent relationship is an increased requirement for confidentiality. Teens may have specific issues requiring privacy but may also want the entire patient/physician relationship to be more private. An adolescent may test the physician's commitment to confidentiality with topics where he or she has nothing to lose. For example, a teenaged girl may come in one day with a 'minor complaint', and when she receives respect and confidential treatment, she may come back for advice about sexuality or birth control.

The appropriate handling of issues of confidentiality is central to building an effective relationship with the adolescent patient.

The topic of confidentiality can be introduced when one starts to see the patient alone for part of the visit (often at around age 12). Most children have never heard the word, but can certainly understand the concept of confidentiality. When describing it, one can mention that issues can be discussed privately and will not be shared with parents without prior discussion with the child. Later, one can make it clear that all interactions are private and shared at the discretion of the patient. This will become important for a teen who wants to discuss family problems, sexual activity (including concerns about pregnancy) and drug and alcohol use.

Adolescents should be informed that in certain situations it is necessary to involve others. The limits of confidentiality should be explained during initial discussions of confidentiality because a teen will feel betrayed if the doctor waits until the teen has disclosed an important piece of information before telling the teen that there are limits to privacy. A doctor cannot keep private conversations that reveal serious suicidal intent or homicidal plans. Child sexual, physical and emotional abuse must be reported, with the definition of 'child' varying among jurisdictions.

There is sometimes concern that a teen will not disclose these feelings or situations to a doctor, having been told that the doctor will not keep it private. It is impossible to know how many patients keep quiet after knowing what could be revealed. On the other hand, teens are unlikely to trust blanket promises of confidentiality. They understand that there must be some exceptions. They are often reassured to know that a doctor will not let extreme situations continue without intervening. When one must reveal information, one can try to respect the adolescent's wishes concerning how to involve others in the situation.

Medical records must also be kept confidential. Keeping the whole family's records in one folder may improve office efficiency, but it increases the chance that a parent will read the adolescent's file. Bookings for investigations should be made from a phone away from the waiting area. Letters containing confidential information should only be sent to referring physicians with the teen's knowledge and permission and should include a reminder that the content is to be kept private. It is sometimes helpful to give the teen a copy of the letter.

Child welfare agencies are not entitled to more information about their wards than are parents, except for reporting of abuse. Workers may try to obtain information about health care visits without the consent of a teen. A variety of agencies and service providers may require a signed consent for release of information upon

intake, but if you suspect that the teen does not want certain information released, you should check before proceeding.

At the same time, it is important that parents not feel left out of the loop. One can ask teenagers what information they would like to have shared with their parents and bring the parents in for this discussion. One can also discuss things from the parents' point of view – find out what their concerns are, address these without breaking confidentiality and provide them with anticipatory guidance about the teen years.

There are many clinical situations in which it is clear that parental involvement is helpful. Yet teens may have unrealistic fears about the consequences of revealing a situation to their parents. A doctor may have confidential information about the parents that leads the doctor to believe that the outcome will be different than the adolescent expects. Work with the teen to help him or her come to an understanding of the importance of sharing information with his or her parents. For example, role playing can help the teen decide the best way to discuss an issue with his or her parents. The adolescent can bring one or both parents to the office to discuss the situation in a safe environment. A doctor's initial assurances of confidentiality and a discussion about disclosure will make it easier for the patient to trust the doctor's judgment about revealing information during joint sessions.

A confidential relationship will encourage meaningful patient/physician interaction, while helping the adolescent move along the developmental path to adulthood.

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