Original Study

Physician Knowledge and Attitudes around Confidential Care for Minor Patients

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A B S T R A C T

Study Objective: Minor adolescent patients have a legal right to access certain medical services confidentially without parental consent or notification. We sought to assess physicians' knowledge of these laws, attitudes around the provision of confidential care to minors, and barriers to providing confidential care.
Design: An anonymous online survey was sent to physicians in the Departments of Family Medicine, Internal Medicine-Pediatrics, Obstetrics/Gynecology, and Pediatrics at the University of Michigan.
Results: Response rate was 40% (259/650). The majority of physicians felt comfortable addressing sexual health, mental health, and substance use with adolescent patients. On average, physicians answered just over half of the legal knowledge questions correctly (mean 56.6% ± 16.7%). The majority of physicians approved of laws allowing minors to consent for confidential care (90.8% ± 1.7% approval), while substantially fewer (45.1% ± 4.5%) approved of laws allowing parental notification of this care at the physician's discretion. Most physicians agreed that assured access to confidential care should be a right for adolescents. After taking the survey most physicians (76.6%) felt they needed additional training on confidentiality laws. The provision of confidential care to minors was perceived to be most inhibited by insurance issues, parental concerns/relationships with the family, and issues with the electronic medical record.
Conclusions: Physicians are comfortable discussing sensitive issues with adolescents and generally approve of minor consent laws, but lack knowledge about what services a minor can access confidentially. Further research is needed to assess best methods to educate physicians about minors' legal rights to confidential healthcare services.
Key Words: Confidentiality, Adolescent health services, Privacy, Informed consent by minors, Parental notification

Introduction

High risk behaviors including substance use, sexual activity, interpersonal violence, and suicide are the primary causes of morbidity and mortality in adolescents.[1] However, less than 20% of adolescents receive recommended screening and counseling on these risky behaviors from their healthcare provider.[2,3] Adolescent patients are unlikely to bring up sensitive issues on their own, but want to discuss these subjects with their physician and cite confidentiality as one of the key determinants of their use of healthcare.[2,4,5] One study showed that 58% of high school students have health concerns they want to keep private from their parents.[6] The most common reason adolescent girls identify for missing a necessary health service is that they do not want their parents to know.[7]

Studies have shown that a lack of confidential care does not delay or dissuade adolescents from engaging in high risk behavior and may lead to unintended health and social consequences.[8,9] In fact, adolescents who forego healthcare due to confidentiality concerns are more likely to engage in risky behaviors and report psychological stress.[10] Federal and state laws have been in place for decades to allow minor patients to receive confidential care for specific healthcare issues related to sexual health, mental health, and substance use. However, physicians have been found to have low knowledge about the laws that exist in their state regarding a minor patient's ability to consent for healthcare services.[11] Patients and their parents are frequently unaware of minor consent laws as well.[12,13]

The majority of primary care physicians support offering confidential care to adolescent patients.[14,15] However, addressing sensitive issues with adolescents can be a challenge. Physicians have cited difficulty having these discussions due to lack of expertise, low patient demand for confidential services, and inadequate staffing.[16] Physicians may have more comfort offering confidential services to older adolescents, but can be less likely to provide this care to younger adolescents,[15] and while some physicians are routinely offering confidential care to their adolescent patients, they may be incorrectly stating the limits of confidentiality.[17]

This study was designed to assess University of Michigan Family Medicine, Internal Medicine-Pediatrics, Obstetrics and Gynecology, and Pediatrics physician knowledge of and attitudes towards Michigan's minor consent and parental

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notification laws. Physician comfort with managing sensitive issues in adolescents was also measured. Finally, we assessed perceived barriers to the provision of confidential care for minor patients. This study serves as a needs assessment to better understand knowledge gaps and barriers (both in attitudes and logistics) to providing confidential care in our ambulatory care clinics. Findings will be used to develop and engage physicians in educational activities with the ultimate goal of improving adolescent healthcare at our institution.

Materials and Methods

All faculty, fellows, and resident physicians in the Departments of Family Medicine (Fam Med), Medicine-Pediatrics (Med-Peds), Obstetrics and Gynecology (Ob/Gyn), and Pediatrics (Peds) at the University of Michigan received an anonymous online survey link via e-mail inviting them to participate in a survey exploring clinicians' knowledge and attitudes related to providing confidential healthcare to adolescent patients. Two reminder e-mails were sent 10 and 20 days after the original invitation. This survey received Medical IRB exemption in June 2013.

The survey was divided in several main sections; starting with physician demographics and practice characteristics including questions on gender, specialty, level of training, length of time as an attending physician, if they are a primary care provider (PCP), the percent of their patient population that is aged 12 to 18, if they have children, and if their children are aged 12 or older. Physicians were then questioned on their level of comfort in addressing sexual health, mental health, and substance use with adolescent patients.

Knowledge of Michigan's confidentiality laws was explored by asking if statements related to a minor's ability to consent for certain aspects of healthcare, physicians' ability to notify parents about this care, and parental health record access were true or false. Physicians were also able to choose if they were uncertain if the statement was true or false, and uncertain answers were coded as incorrect in the analysis.

To explore clinician attitudes, Michigan minor consent and parental notification laws were then provided, and participants were asked if they approved, disapproved, or felt neutral about each law. Attitudes were further examined by asking physicians to rate their agreement with statements regarding an adolescent's right to confidential care, adolescent maturity in making care decisions, and parental rights to notification of healthcare provided to their minor child.

Finally, physicians were questioned on their ability to provide confidential care to minors seen in the outpatient clinic setting, and what barriers they felt inhibited their provision of confidential care.

Associations between demographic information, knowledge, and attitudes were explored using t-tests, ANOVA, and Pearson's correlation as appropriate.

Results

Survey Demographics

The survey link was sent to 650 potential participants. Three hundred and nineteen physicians began the demographic questions, and 259 answered the knowledge questions about minor confidentiality laws and were included in the analysis for an overall response rate of 40%. Characteristics of survey responders compared to all potential participants are shown in Table 1.

Comfort with Discussing Sensitive Subjects with Adolescents

On a scale of 1 (very uncomfortable) to 5 (very comfortable), the majority of physicians felt comfortable addressing sexual health (mean 4.07 ± 1.12), mental health (3.97 ± 1.02), and substance use (3.89 ± 1.09) with patients aged 12 to 18.

There was a trend towards difference by physician specialty in comfort addressing sexual health in this age group, with Ob/Gyns being most comfortable and pediatricians least comfortable (Ob/Gyn mean 4.38 ± 1.21, Med-Peds 4.31 ± 0.75, Fam Med 4.09 ± 1.07, Peds 3.94 ± 1.10, $P = .08$). Female physicians felt significantly more comfortable discussing sexual health than male physicians (females mean 4.18 ± 1.07, males 3.81 ± 1.8, $P = .02$).

Physicians with children aged 12 or older were more comfortable addressing mental health and substance use in this age group than those without adolescent children (with children aged 12 or older mean 4.28 ± 1.07 vs without 3.86 ± 0.99, $P = .01$ for mental health and 4.07 ± 1.05 vs 3.75 ± 1.13, $P = .07$ for substance use), but were not more comfortable discussing sexual health (4.07 ± 1.25 vs 4.10 ± 1.07, $P = .90$).

There were no other differences in comfort addressing sensitive subjects with adolescents by specialty, gender, level of training, length of time as an attending physician, if the physician was a PCP, or percent of patient population that is adolescent.

Knowledge of Michigan Laws

On average, physicians answered just over half of the legal knowledge questions correctly (mean 56.6% ± 16.7%), see Table 2. When grouped by topic, physicians varied on the percent of questions they answered correctly (percent correct on questions about health records 63.1% ± 33.8%, sexual health 57.9% ± 19.3%, mental health 53.5% ± 30%, substance abuse 47.7% ± 31.7%, $P = .03$). Physicians answered more questions correctly about minors' ability to consent for care (65.8% ± 19.9%) compared to questions around parental notification of care (24.5% ± 35.4%), $P < .01$. When questions provided the same scenario with an older minor (age 17) compared to a younger minor (age 13), physicians were more likely to answer correctly for the older minor ($P < .001$).

There was a trend towards difference in number of knowledge questions answered correctly by specialty (Fam Med 61.9% ± 16.3%, Ob/Gyn 56.3% ± 13.4%, Peds 55.2% ± 17.4%, Med-Peds 52.2% ± 13.8%, $P = .06$), and a statistically significant difference by gender (females 58.4% ± 15.2%, males 52.3% ± 19.3%, $P = .01$), and whether or not the physician was a PCP (PCPs 60.6% ± 14.6%, non-PCPs 52.1% ± 17.8%, $P < .01$). There was no statistically significant difference in number correct based on level of training,