Adolescents & Confidentiality In Singapore

Does the mature minor have a right?

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Case study (fictitious scenario):

The mother of a 15-year-old patient was asked to pay for her daughter's medical bill as she had consulted a general practitioner. She repeatedly phoned the clinic and demanded to know the reasons for which her daughter had been seen. She sounded upset and anxious and demanded to speak with the GP involved. Mom suspected that the GP had prescribed antidepressants for her daughter. She wanted to obtain a copy of her daughter's medical records and was threatening to get her solicitor involved. The GP spoke very briefly, gave bare information, and refused to give the diagnosis or any details. A week later, the GP received a letter from the local medical council asking for an explanation as mom had made a formal complaint. The GP was uncertain about his legal obligations and liabilities in this situation. The GP then asked his senior colleagues for advice.

"Health care professionals regularly struggle with providing care to adolescents, especially in relation to issues of confidentiality and consent in terms of physical and/or mental health issues. Although many adolescents have the maturity to decide the course of their health-related decisions, their right to confidentiality sometimes rests in the hands of those professionals who provide their care."[1]

INTRODUCTION

Is a child considered as having grown into an adult in a multi-cultural and multi-religious society such as Singapore or Malaysia? Here, children graduate from secondary schools to junior college in late adolescence (16 to 18 years old). Yet, mostly we consider them as "under-age" if they are below the age of 21 years, which is the age of majority under the law in Singapore.

Note that contracts entered into a person who has attained the age of 18 has effect as if he were of full age (Section 35 Civil Law Act 1909.) There is no legislation excluding contracts for medical care and treatment. The grey area is below 18, as in the hypothetical scenario above.

It has been a common misunderstanding that in Singapore, the boys (or should we say, men) who enter conscripted military service at age 18 years are being trained to shoot to kill in battle yet cannot make decisions about their own medical issues. As can be seen from the above paragraph, an 18-year-old can enter into contracts, which would include contracts for medical care and treatment.

There are two positions taken in this topic: the so-called Western (liberal) vs the Asian-Eastern (conservative) approach. There is a commonly taken third and middle-of-the-road compromise approach, which is quite a shifty and slippery position, of no help in making decisions.

Medical journals in the English language are dominated by the Western-liberal approach, as in the recent literature search conducted by this author while preparing for this article. The individual is seen as all-in-one and no one else has dominion over the individual. It is a purist's approach and has its philosophical and practical merits. Even younger Asians in Singapore or Malaysia are likely to come to embrace this approach. Times are changing in Asian societies, especially with the arrival of the Internet.

However, in the local culture, by and large, the societal view is quite different, especially in non-English speaking families and communities. This is made more confusing by the diversity in a multicultural nation.

DIVERSE VIEWS FROM LOCAL PRACTISING DOCTORS

Based on the discussions with local doctors regarding the above scenario, below are some of the views gathered. They reflect the views of various doctors in active practice in Singapore, from diverse racial backgrounds and medical specialties:

- A GP who focuses on mental health asked "Have you considered the case **as a family**? Have you managed this case as a family?"
- A teacher of ethics asked: "Confidentiality: To disclose or not to disclose? If yes, how much to disclose? Communications: In what ways did the communications **with the mother fail**?"
- An internist commented: "**Ask the child for permission to speak** with the mother at a **very early point in the initial consultation**. Make sure the child understands **your policy** of having to speak with the parent. Bear in mind that, at some point in the therapeutic relationship, **you will have to call for a family conference**."
- **A psychiatrist said**: "**Consider 2 persons in the psychiatric consultation**. That you will have to **do 2 interviews** – one alone with the child and one with both child and parent. **Assess the mother** as much as you assess the child. Is she anxious, aggressive, or antagonistic? How likely **is she to be a source of stress**/problem for the child? In family practice, you don't have much **time**, so **stage your disclosure** of information to the parent.

The psychiatrist added:

- Some areas of the case can be asked in subsequent/future consultations.
- At each encounter with the parent, based on your professional judgement, decide **how much information the mother needs** to hold and disclose to the parent just sufficient for her to have some basic understanding.
- Disclosing all information without **discretion** may be detrimental to the mother if she is not ready to accept the child's condition or diagnosis.
- Be **judicious about how much to disclose** to the parent.
- But, at the end of the day, in the **Asian context**, the needs of a parent who hold parental responsibility, you must address the **needs of the mother in carrying out her duty as a parent caring** for her child, her role as a **caregiver**.
- The **appropriate amount**, and what **type**, of information to be disclosed is based on your professional judgement at that point in time.

Other doctors said:

- **Don't even disclose anything** to the parent as she has no right to know at all.
- **Western cultures are individual-centric** whilst Asian cultures are **family-centric**. You practise in the **context of the culture that you are practising in**.
- Be **discretionary** when disclosing information to the parent.
- Psychiatrists always **interview** the **patient's relatives in a separate visit**.
- You must **strike a balance** between the rights of the child and the needs of the parent for appropriate information so that she can carry out her duties as a parent and guardian.
- You need to appraise if the mother is the **source of the problem** for the child.
- You must decide if there is a need to **refer the child** to a specialist or to a counsellor for support.
- You need to ensure the **safety of the child** first whilst allaying the anxiety of the parent.
- At all times, you must put the **child's "best interest** first and foremost".
- Decision to treat can be delayed until the next consultation as it is "not an emergency. This is the concept of 'Delayed Decision'".

As can be seen, the views on the ground are diverse. Left to practising physicians without guidance from the local medical authorities and the law, there is not much agreement as to how to approach a mature minor.

DEFINITION – A MATURE MINOR

Most of the definitions of a mature minor come from Western countries.

One such definition is "*(An adolescent) Who may consent [or withhold consent for] surgical or medical treatment or procedures...* Any unemancipated minor of sufficient intelligence to understand and appreciate the consequences of the proposed surgical or medical treatment or procedures, for himself." By definition, a "mature minor" has been found to have the capacity for decisional autonomy, or the right to make decisions including whether to undergo risky medical but potentially life-saving medical decisions alone, without parental approval.[2]

"A very common case quoted is the principle of Gillick competence as discussed in Gillick v West Norfolk and Wisbech AHA [1986]" We have no local cases but it is common in Singapore consider the Gillick's case as instructive.[3,4]

"The provision of confidential health care to adolescents goes hand in hand with the ability of adolescents to consent to their own medical treatment. If an adolescent is able to consent to their own treatment, then they are medicolegally entitled to the same doctor-patient confidentiality as an adult patient."[5]

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BENEFITS (BENEFICENCE) TO THE ADOLESCENT INDIVIDUAL

Why is it important?

Confidential care for adolescents is important because it encourages access to care and increases discussions about sensitive topics and behaviours that may substantially affect their health and well-being.

Mainly it promotes an adolescent's access to timely healthcare services and treatment.

In 2007, Kirby summarised seven available published, well-designed, randomised controlled trials of parent interventions designed to influence adolescent sexual behaviour, delayed initiation of sex, reduced frequency of sex, increased condom use, decreased the number of self-reported pregnancies, and decreased the number of self-reported STIs.[6]

BARRIERS TO PROTECTION OF CONFIDENTIALITY

PHYSICIAN BARRIERS

Even in other countries, many healthcare providers have not received adequate training on issues in matters of confidentiality for adolescents. As a result, they may avoid any discussion of confidentiality. One study showed that even within a single state, only 56% of surveyed physicians brought up confidentiality with any adolescents.[7]

PARENT BARRIERS[8]

Parents themselves are often unwittingly a barrier to protecting confidentiality for their mature adolescents. This is especially so for Asian families where parents see children as an extension of themselves and need their (lifelong) protection and intervention (even to the point of arranging for marriage partners). Often, their understanding of confidentiality is that of "keep things private within the family from outsiders" rather than privacy unto the individual adolescent. The family is the unit, and the individual is not seen as a unit.

Some of the parental factors are:

Low knowledge about confidentiality — Studies indicated that parents have a limited understanding of confidentiality protections for adolescents. A qualitative study of Latino parents of 12- to 17-year-olds found that some parents believed confidentiality meant information was kept private between adolescent, provider, and parent.

Mixed support for confidentiality — Most participants in the aforementioned qualitative study of Latino parents acknowledged that confidential care helps young people feel more comfortable talking to providers, including about sexual health, and helps providers obtain accurate health information. Yet, a national online survey of parents found that 61% of respondents preferred to be in the examination room for the entire clinic visit. A different national web survey found that 46% of parents wanted full disclosure of confidential information obtained from adolescents during time alone, despite being informed of laws prohibiting this.

Parental norms conflict with confidentiality — A qualitative study of Latina and Black mothers of adolescent girls 16-19 years found that many mothers were uncomfortable with confidential care because they worried providers would ask developmentally inappropriate questions (e.g., related to sexual activity). Latino parents in another qualitative study also expressed concern about not having important information to help their adolescent stay safe and healthy. In fact, some parents believed they had a right to this information because they were responsible for their teens.

So, there is anxiety on the part of parents who are unwilling to "let go". This is understandable, especially in family-oriented communities in Asia.

ONE SUGGESTED PRACTICAL APPROACH

In the first draft, I hesitated in giving an answer as I wanted readers to figure out the answers for themselves. However, some who read an early draft asked for some form of answer as closure for readers who would rather not be left with a cliffhanger. In ethical discussions, there are so many different points of view. Also, in a given ethical dilemma case scenario, especially one with so many gaps of information, there may be no simple solutions.

Perhaps, one possible answer to the case study conundrum would be to advise that for adolescents between the ages of 15 and 18, the following approach be taken:

1. Consider what would be in the patient's best interests.
2. Is the patient competent in understanding and making decisions for his/her own care?
3. Can agreement to involve the parent be obtained?
4. If the patient's interest is to not disclose, the doctor should be guided by that.
5. However, if the patient's interests favour disclosure but he/she refuses disclosure of information to the parents (and is competent to undertake his/her own care), we go back to the principles of acting in the patient's best interests and doing no harm.

Perhaps further training of doctors to go through these steps to achieve boundaries for competent persons under 18 at first consultation would be helpful.

CONCLUSIONS AND RECOMMENDATIONS

In the Asian context, this matter is still complicated and a struggle for both physicians, parents, and the adolescent. When the matter reaches a complaint department or a medical tribunal, decision-makers are also left with a headache and an ethical challenge. Who is right, who is wrong, and what are we trying to achieve here? Is it purely a problem in communications or is it a more deep-seated issue with philosophical ethical basis.

What do our local societies and communities want?
What do our medical bodies, academies and colleges say?
Do we need more guidelines in our daily approach to mature minors?
What laws, if any, need to be made?

There needs to be more research into this area. How much or how big is the problem?

Left to ourselves, each physician interprets the encounter with the child and parent in our own blundering ways. Is there a need for a unified approach, something we (doctors and parents), as a society and as a profession, can all agree upon?

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CFPS will be organising a series of Zoom sessions based on the 12 Care Protocols developed by MOH for family physicians as part of the drive towards Healthier SG. They will be held every Tuesday night from 9:30pm to 10:30pm starting 2nd May through 27th June 2023. This series will run again from August to October during lunch time. It will cover topics like health plan; cancer screening; cardiovascular risk assessment screening; BMI control; adult vaccination; smoking cessation; pre-diabetes; diabetes; hypertension; hyperlipidemia; multi-morbidity; and GP first. Do visit the college website nearer the date for the link, which will direct you to the materials required for pre-reading. The Zoom details will also be released through the website one week before the event. It is free and CME points will be awarded. Do look out for it. See you all – Live from CFPS. It's Tuesday night!