Health promotion, the family physician and youth
Improving the connection

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**Background.** There is evidence to link adolescent morbidity and mortality with their high-risk behaviour. As a result, the medical community has increased its focus on health promotion and disease prevention. Family physicians, in particular, appear to be in an optimal position to intervene. There is little information, however, on how adolescents would perceive such interventions.

**Objective.** This study was designed to gain an understanding of adolescents’ perceptions about the role of family physicians in health promotion and disease prevention.

**Methods.** Qualitative methodology was used involving focus groups. The groups were conducted in community organizations for youth. Fifty-four adolescents ages 13–17 participated in seven focus groups. Themes were derived from qualitative analysis of the data.

**Results.** Four themes were found: (i) adolescents are concerned about the potential direct consequences of the health behaviours they engage in; (ii) adolescents use family physicians primarily to address biomedical health issues rather than to discuss non-acute health concerns; (iii) adolescents are reluctant to discuss health concerns with family physicians because they are worried about lack of confidentiality; and (iv) adolescents choose to speak to specific individuals based upon how comfortable they feel talking to them about specific health concerns.

**Conclusion.** This study found that the adolescents did not see the role of the family physician as a health promoter. The themes help provide family physicians with a better understanding of how adolescents perceive them. With this understanding, improved ways of creating doctor–patient relationships with adolescents may be developed.

**Keywords.** Adolescent, family physician, health promotion.

**Introduction**

Adolescence is a complex transitional stage with rapid physical and behavioural change. Part of adolescent development includes experimentation. There is compelling evidence to link adolescent high-risk behaviours with poor morbidity and mortality outcomes. For example, cigarette smoking, which is initiated primarily in adolescence, significantly increases long-term cancer risk.1 Similarly, early sexual activity increases the risk of sexually transmitted disease (STD) and cervical cancer.2

The potential negative impact of adolescent risky behaviours has led primary care physicians to engage health promotion and disease prevention strategies with their adolescent patients.3 It is unclear, however, how adolescents perceive these strategies.

Studies that have used qualitative methodology have been able to explore adolescents’ experiences, perceptions and preferences about health care and health promotion. A recent American study revealed that urban adolescents are most concerned with being respected and treated well by primary care providers. They also expressed a desire to be listened to, to have their problems taken seriously and to be treated with dignity and respect.4 It appears that qualitative studies may provide clues into adolescents’ perceptions about the role family physicians should have in their health care.

This study examines adolescents’ perceptions of the role of the family physician in health promotion and their views about the ways in which preventive health services could be provided to them. It is unique in that it is a Canadian qualitative study that uses focus groups. It is intended to help family physicians gain insight into how they can engage effectively in health promotion interventions among the adolescent population. With
this knowledge, it is hoped that family physicians can improve the quality of their health promotion activities with adolescents in order to effect a change in their health risk behaviours and ultimately in their health outcomes.

Methods

A growing body of literature has advocated the qualitative approach as the method of choice in descriptive research. Research that attempts to uncover the nature of a person’s experiences naturally lends itself to qualitative analysis. Focus groups, used in this study, incorporate group interaction as part of the research process; the facilitator and the participants explore and clarify their views in ways that may not surface in surveys or one-to-one interviews. The focus group capitalizes on the dynamic communication between adolescent participants and is an efficient way to examine the range of opinions and experiences that adolescents have.

Prior to starting the focus groups, a preliminary literature review was completed in order for the researchers to gain familiarity with past research and to generate research questions. In qualitative research, the researcher comes to the research situation with some background in the literature. It has been suggested that conducting an in-depth literature review may bias the researchers’ perspective and influence the analysis of qualitative data. Thus, during the ongoing analysis of the data, a further comprehensive literature review was undertaken searching MEDLINE, Cinahl and Psychlit databases from 1993 to 2000. This extensive literature review helped guide emerging theory in subsequent focus groups and validate the study’s findings.

Two of the study’s investigators are academic family physicians affiliated to The Toronto Western Hospital, and one was a medical student. Ethics approval was obtained from the Ethics Committee at the Toronto Western Hospital.

Sampling

Adolescent males and females, ages 13–17, were recruited from existing youth groups that were associated with after-school programmes at local community agencies in Downtown West Toronto. The community of West Toronto is known for its diversity across a multitude of factors including ethnicity, languages, socio-economic status and lifestyles. Approximately 85.8% of residents in the West Toronto area reported ethnic ancestry other than British or Canadian. Local neighbourhood data for the West Toronto community reveal tremendous disparity in income at the local level. Five distinct community agencies were approached and all agreed to help in recruiting youth to participate in the study. The youth workers verbally asked the youth attending their agency to participate. As a result, the response rate could not be calculated specifically.

Consent

In some Canadian provinces including Ontario, there is no relevant legislation clearly to address the issue of consent from minors. Some take the view that as long as the child has the necessary maturity, understanding and appreciation of the nature and consequences of participation (‘mature minors’), they can consent to research on their own behalf. Moreover, the youth interviewed had received parental consent to attend the community agency programmes and consent was received by the community agencies to conduct the study with the youth within their programmes. The agencies reviewed the questions to be posed and ensured the presence of a youth worker at the time of the session. A written consent form was given to all subjects to sign. Verbal informed consent was also obtained from each subject at the time of the interview to ensure that participants understood the purpose of the study and could have the opportunity to ask questions. All subjects were told that they could refuse to answer any question posed and were not obliged to talk about anything they felt uncomfortable discussing. Their participation was completely voluntary and their compliance or lack thereof would not compromise them in any way. The audio-taping process was explained, stressing that anonymity and confidentiality would be maintained. A light meal and a movie gift certificate valued at $10 were given to each participant to compensate them for their time.

Interviewing the youth in their respective community agencies where they attended regularly also provided the opportunity for a youth worker to be present during the focus groups acting as a witness and helping to provide a sense of security for the youth participants. Their presence ensured that if any health problems were uncovered with any of the youth in the study, the youth would be provided proper follow-up.

Focus group setting

The focus groups were conducted at the respective community agencies because it was felt the adolescents would feel more comfortable in a familiar setting, would not have to travel to another location and would have the community agency workers, whom they trusted, present.

Data collection

Prior to each session, each participant was asked to complete a brief demographic information survey. A facilitator, who was not one of the investigators, conducted the focus groups. A focus group guide was developed to provide a consistent framework for each interview. Based on the literature review, the guide consisted of questions that would elicit in-depth knowledge about adolescents’ health concerns and their opinions and experiences regarding the role of the family doctor in health promotion. The guide attempted to limit variation in the questions posed without preventing
Adolescents choose to speak to specific individuals based upon how ‘comfortable’ they feel talking to them about specific health concerns. Adolescents are reluctant to discuss health concerns with family physicians because they are worried about lack of confidentiality. Adolescents use family physicians primarily to address biomedical health issues rather than to discuss preventative health concerns. Adolescents are concerned about the potential consequences of the health behaviours they engage in.

**Results**

Fifty-four adolescents, 28 males and 26 females, participated in the study. Eighty per cent could identify having a family physician of their own and 88% had visited a doctor at least once in the last year.

Four themes emerged from the analysis of the focus groups (see Table 1).

### Table 1  Themes

| Adolescents are concerned about the potential consequences of the health behaviours they engage in. |
| Adoelcents use family physicians primarily to address biomedical health issues rather than to discuss preventative health concerns. |
| Adolescents are reluctant to discuss health concerns with family physicians because they are worried about lack of confidentiality. |
| Adolescents choose to speak to specific individuals based upon how ‘comfortable’ they feel talking to them about specific health concerns. |
facing youth, especially health promotion issues and disease prevention. Mixed responses were obtained, but the general feeling was of reluctance. “If they ask me a question I’ll be honest—but I’m not going to go out of my way to go . . . go on and ask me if I smoke weed.” Other youth described the probing of doctors about high-risk behaviours in a negative way. “Like that’s my personal stuff. And if I wanted to tell her (doctor) or ask her I would.” Often the reluctance to discuss their health concerns and high-risk activities was related to confidentiality issues.

Adolescents are reluctant to discuss health concerns with family physicians because they are worried about lack of confidentiality

“I don’t feel comfortable talking to every doctor ‘cause everything we talk about goes back to the nurse and then the nurse tells her husband about it and her husband says something and it goes around the whole neighbourhood.” The adolescents interviewed had strong feelings of distrust towards physicians. “Family doctors tell your parents!” Trust was an important issue related to confidentiality. “Trust is something you have to build, you don’t automatically have trust for doctors.” Some youth indicated that trust could be developed with family physicians especially if a long-term relationship had been developed. “I tell my doctor that I smoke—just ‘cause I trust him. I’ve known him all my life.”

Adolescents choose to speak to specific individuals based upon how ‘comfortable’ they feel talking to them about specific health concerns

The youth identified various individuals as people they would talk to about health concerns. The individual chosen depended on what the specific health issue was and their comfort level with the person. Some youth identified youth workers. “They’ve been through it before . . . they have a way with words, like they’re not just there to preach to you—they’re there to help you.” Others identified their parents. “I’d go to my mom, me and my mom are the closest together and so she would help me . . . I can trust her about everything.” Even teachers were mentioned. “Only the teachers that like you . . . do the things you do . . .” Thus it was clear that there was no single person that adolescents went to with their health concerns.

Discussion

This study provides insight into adolescents’ perceptions of the role of the family physician in health promotion. Many family physicians remain unaware of the experiences adolescents have when they visit them in their office. The narratives of the adolescents in this study which formed the basis for the themes developed can help family physicians improve their understanding of what youth experience during their interactions with doctors, particularly when issues of health promotion are discussed.

Adolescents are concerned about the potential direct consequences of the health behaviours they engage in

As discussed earlier, adolescents are engaging in health risk behaviours. This study revealed that their health concerns were related to direct and more immediate consequences of their health behaviours as opposed to long-term effects such as developing cancer. Experiencing or witnessing the potential negative side effects of some of the risky behaviours they were undertaking influenced their decision of whether to engage in those behaviours in the future. Adolescents are curious, want to experiment and need to define their personal boundaries. As such, a more prudent approach to health promotion may be necessary to advocate harm reduction methods where interventions focus on decreasing the harmful consequences of health risk behaviours rather than the elimination of their use altogether. Perhaps family physicians should work with adolescents to identify specific concerns regarding their health risk behaviours and educate them about the risks of the behaviour rather than attempt to eliminate those behaviours. These types of dialogues may help youth develop critical decision-making skills which ultimately may enable them to increase control and improve their health.

Adolescents use family physicians primarily to address biomedical health issues rather than to discuss non-acute health concerns

Canadian guidelines clearly recommend that family physicians should provide adolescent preventative health services. Surprisingly, many adolescents remain unaware that family physicians provide this role. Moreover, many of the adolescents in this study were opposed to the family physician addressing anything other than biomedical issues. The literature in this area is contradictory. Some studies have shown that adolescents want physicians to give them health information and to ask personal questions about STDs, sexual activity and depression. Yet others show that adolescents generally are reluctant to talk about prevention issues with physicians. It is clear that if adolescents do not understand why questions are being posed to them and if a relationship has not been developed with the person who is posing these questions, there will be reluctance to discuss these highly sensitive issues. Thus, it may be necessary first to dispel the adolescent myth that family physicians deal only with biomedical concerns. In addition, they must develop a trusting relationship with youth before highly charged questions can be posed. In fact, trust is identified as a key concern in their relationship with doctors.
Adolescents are reluctant to discuss health concerns with family physicians because they are worried about lack of confidentiality

This theme revealed information consistent with previous studies which have found that adolescents identify lack of confidentiality as a major reason for not seeking health services from physicians. Confidentiality as an issue is often not addressed by physicians. One American study surveying family physicians, internists, gynaecologists and paediatricians showed that only 53% discussed confidentiality issues with adolescents. Of the physicians who responded, 64% gave unconditional confidentiality where the physician stated he would never disclose information about anything discussed. In addition, 36% gave conditional assurances where the physician stated he might need to disclose information under certain circumstances. Conditional confidentiality follows most professional and legal guidelines for the limitations of confidentiality, including issues of disclosure related to sexual abuse and suicide. In one study, adolescents revealed that they were more likely to seek health care from physicians who assured them of conditional confidentiality. Confusion about confidentiality rules was a significant finding in this study. Each focus group had adolescents asking about their rights. It may be interesting to determine rates and types of confidentiality assurances given by physicians in a Canadian context. This study suggests that conditional confidentiality should be assured, and time spent clarifying confidentiality rules may lead to the development of trusting relationships with family physicians.

Adolescents choose to speak to specific individuals based upon how comfortable they feel talking to them about specific health concerns

A Canadian study found that adolescent females within the study felt more comfortable with female physicians, wanted their physicians to be more like their friends and wanted to be treated not as children nor adults but as “teenagers” by their physicians. This qualitative study provides initial clues into adolescents’ perceptions of the family physician. Adolescents in this study identified various individuals whom they talk to about their health concerns. New ground was broached by examining this issue. There is a complex interplay of factors needed to determine who an adolescent turns to for health advice. It was found that the individual an adolescent chooses to speak to is dependent upon how comfortable they feel talking about a specific health concern with that particular person. This comfort level was based on several factors (see Table 2). Some of the predominant factors identified were trust, experience, knowledge and choosing someone who is non-judgemental, caring and either knows or does not know them. This model takes into account why adolescents may choose to speak to an adolescent frontline worker whom they know well. It also explains why they may want to go to an anonymous STD clinic. At the STD clinic, they may feel more comfortable seeing someone who is non-judgemental, experienced and knowledgeable in the area but does not know them in order to avoid embarrassment.

Are family physicians considered within this complex interplay of factors? Very few of the youth identified physicians as individuals they would go to with their health concerns. Thus, perhaps family physicians need to examine the factors identified by the youth as important to them in making this decision and maintain an awareness of the qualities which determine the comfort of the adolescent. Having a doctor who they feel comfortable coming to will increase disclosure of health concerns and may facilitate effective health promotion interventions. This theme also supports the concept of expanded multidisciplinary primary care. This notion is supported in a Canadian study consisting of involvement of family physicians in a school health programme which concluded that opportunities exist for family physicians to expand their involvement in child and adolescent health in schools and that this involvement should be collaborative and multidisciplinary. Clearly, family physician initiatives cannot stand in isolation.

Potential challenges and limitations

This study has several limitations. Two of the investigators are family physicians who both have a strong interest in adolescent medicine, which may have biased their views. Also the response rate of those asked to participate was not calculated. This study focused on adolescents recruited from youth community agencies in urban Toronto. Their responses may not be generalizable to other geographic settings or to adolescents with different cultural or socio-economic backgrounds.

Conclusion

This qualitative study provides unique information about the role of family physicians in health promotion from an adolescent perspective. The current findings point to the need for family physicians to inform adolescents that their role goes beyond addressing biomedical problems and includes health promotion and disease prevention. Adolescents are concerned about the potential direct consequences of the health behaviours they

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<th>TABLE 2</th>
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engage in. Family physicians have a window of opportunity to discuss these consequences, perhaps using a harm reduction approach. By developing relationships based upon factors which make youth feel more comfortable, including ensuring confidentiality, family physicians may optimize their therapeutic relationships with adolescents and perhaps have a positive impact on their future health. The concept of participating in a multidisciplinary team approach to adolescent health promotion is also key. This improved understanding of adolescent experiences ultimately can assist family physicians in improving their health promotion connection with adolescents.

Acknowledgements

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