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Clinical Conversations About Health: The Impact of Confidentiality in Preventive Adolescent Care

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A B S T R A C T

Purpose: To better understand how confidentiality impacts the delivery of preventive adolescent health care by examining adolescent and parent beliefs and the relationship between confidentiality and the number and subject matter of health topics discussed at the last visit.
Methods: This study represents a secondary analysis of nationally representative online survey data collected from adolescents aged 13–17 years (N = 504) and parents of adolescents aged 13–17 years (N = 500). Descriptive statistics were conducted on confidentiality variables of interest. Analysis of variance and Scheffe post hoc tests were computed to determine whether the mean number of topics discussed varied by level of confidential consultation provided. Associations between confidential consultation and health topics discussed at the last visit were examined using multivariate logistic regression.
Results: Approximately, half of both samples reported provision of confidential consultation. Eighty-nine percent of parents believed adolescents should be able to speak with providers alone, yet 61% preferred to be in examination room for the entire visit. Nearly half of all adolescents believed parental presence impacted conversation. Mean number of topics discussed was significantly higher when a visit was partially confidential (4.11 ± 3.05; $p = 0$) versus when a visit was not confidential (2.76 ± 2.68; $p = 0$). There were significant associations between confidential consultation and discussions about 8 of 11 health topics.
Conclusions: Confidential consultation significantly impacts the number and subject matter of health topics discussed. A split-visit confidentiality model for adolescent preventive care visits may result in clinical conversations that address more topics. This arrangement may also appeal to parents who have mixed feelings about confidentiality.

IMPLICATIONS AND CONTRIBUTION

This study demonstrates that the provision of confidential consultation significantly impacts both the number of health topics discussed with adolescents during preventive care clinical encounters and the subject matter of clinical conversations, in ways not previously shown. This study also supports previous findings that parents are conflicted about adolescent confidentiality.

Conflicts of Interest: Original data collection was conducted by the National Foundation of Infectious Diseases with financial support from Pfizer. The authors received no compensation for this secondary analysis of the data, or the writing of this manuscript, from either source. All findings and conclusions are those of the authors alone. V.I.R. serves on the U.S. Advisory Board for Human Papillomavirus for Merck & Company, Inc. as well as on the Merck & Company, Inc. Speaker's Bureau. He previously served on the Adolescent Health and Wellness Advisory Boards for Pfizer Pharmaceuticals, Inc. A.L.G. and M.C.A. have no potential conflicts of interest to report. A.L.G. wrote the first draft of this manuscript.

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Implementation of the Affordable Care Act (ACA) is projected to result in increased numbers of adolescents accessing primary and preventive care services. Three reasons for this anticipated influx are that individuals may no longer be denied insurance coverage for preexisting conditions; coverage is assured for essential health benefits including a variety of preventive health services; and coinsurance, deductibles, and co-payments cannot be charged for an important subset of such services [1].

It has previously been established that adolescents are more likely to seek care, disclose sensitive health information, and

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return for future care if confidentiality is assured [2–6]. These findings are not particularly surprising given that adolescent morbidity and mortality are frequently related to sensitive health-risk behaviors [7]. Inversely, adolescents who report forgoing care due to concerns about confidentiality are more likely to report engaging in high-risk behaviors [8]. For these reasons among others, professional organizations including the American Medical Association [9], American Academy of Pediatrics [10], and Society for Adolescent Health and Medicine [11] specifically recommend the provision of confidential health services for adolescents.

Findings regarding parental support for adolescent confidentiality have been more mixed. Although it has been shown that parents are able to identify many of the benefits of confidentiality [12], they also report concerns that it may promote risky behavior or undermine their ability to protect their adolescent child [13]. Furthermore, many parents believe that physicians should, or will, inform them about everything that has been discussed with their adolescent [12].

The breadth of state and federal laws, ethical guidelines, and professional recommendations addressing confidential health services for adolescents is vast, and the boundaries of the protections they provide are not always clear [7,14]. Confidentiality in the context of adolescent primary care requires not only the provision of private consultation (one-on-one clinical conversations with adolescents without parents present) but also assurances that standard health care payer practices will preserve confidentiality after care has been delivered. Research that more clearly illustrates the clinical importance of confidentiality for adolescent populations, and parent and adolescent beliefs regarding its provision, is necessary to inform meaningful and appropriate policy implementation as the ACA continues to roll out.

Using a nationally representative sample, this study first examines adolescent and parent beliefs regarding the provision of confidential consultation in preventive care settings. The relationship between the provision of confidential consultation and the number and subject matter of health topics discussed at the last visit is then examined to better understand how confidentiality impacts the delivery of preventive adolescent care.

Methods

Overview

This study represents a secondary analysis of data collected by Harris Interactive, Inc. (Harris Interactive, Rochester, NY) between December 2012 and January 2013 using online surveys that targeted adolescents aged 13–17 years (N = 500) and the parents of adolescents aged 13–17 years (N = 504). These surveys were conducted by the National Foundation of Infectious Diseases in collaboration with, and with support from, Pfizer Pharmaceuticals (Pfizer, New York, NY) to better understand key issues and barriers in promoting adolescent health. Although these surveys have previously been described in the literature [15], methodological details relevant to the present study are included in the Methods section. The authors played no role in the development of the original survey instruments. This study was approved as exempt by the Indiana University Institutional Review Board for Human Subjects.

Study samples

Parent respondents were recruited from online panels maintained by Harris Interactive. To establish a sufficiently large adolescent sample, parent panel members were asked to refer their own children aged 13–17 years for recruitment. To ensure distinct study populations, parents whose adolescents were recruited in this manner were not eligible to participate in the parent survey. All potential respondents were invited to participate via email and given a unique, password-protected link to the appropriate self-administered screening/survey tool, which was hosted on a secured Web site. Respondents were eligible to participate in the parent survey if they resided in the United States and were 18 years of age or older and reported having at least one child between the ages of 13 and 17 years living in their household. Respondents were eligible to participate in the adolescent survey if they resided in the United States and were between the ages of 13 and 17 years. Confidentiality was maintained by separating all personally identifiable information from research results at all stages of the study. On average, parent respondents took 23 minutes to complete the survey and adolescent respondents took 24 minutes. All respondents were provided compensation in accordance with the incentive structure agreed to on panel recruitment, which grants reward points that can be redeemed for products or services on survey completion. For the surveys described herein, respondents were provided with 100 reward points (approximately $.80) on completion.

Survey instruments

Content for the online surveys was developed by Harris Interactive in collaboration with National Foundation of Infectious Diseases and Pfizer and programmed, tested, and quality approved by Harris Interactive. Before launch, both surveys were piloted and amended as necessary to ensure the quality and accuracy of the content, the clarity of the questions and instructions, and the ease of participation.

The surveys were primarily comprised close-ended questions with established response categories. The parent survey included questions about the following demographics: country/region of residence, state/territory of residence, gender, age, age of children in household, gender of children in household, race/ethnicity, Internet usage, employment status, highest level of education completed, and income category. The parent survey also asked respondents about a range of health concerns, beliefs, and experiences in relation to their adolescent children, including questions regarding the provision of confidential health services. Parent respondents were asked to answer all questions based on their adolescent child's last annual checkup with a physician, at which the adolescent was neither injured nor sick. The adolescent survey included demographic questions about country/region of residence, state/territory of residence, gender, age, grade, race/ethnicity, Internet usage, urbanicity, highest level of education completed by mother, highest level of education completed by father, sibling age, and the number of people under age 18 years living in the household. Frequently mirroring questions in the parent survey, the adolescent survey asked respondents about their own health concerns, beliefs, and experiences at their last annual checkup with a physician, at which they were neither injured nor sick.

Survey weighting

Final survey data were weighted by Harris Interactive to be representative of the U.S. population as a whole. Adolescent data were weighted using highest adolescent-reported education level in household, age by gender, race/ethnicity, geographic region, and urbanicity. Parent data were weighted using highest self-reported level of education, age by gender, race/ethnicity, geographic region, and income. Propensity weighting was also done to reduce any bias inherent to the online panel samples.

Statistical analyses

We first conducted descriptive statistics on sociodemographic and confidential health services variables of interest contained in both the parent and the adolescent data sets. We then turned our attention to the adolescent data and computed an analysis of variance to determine whether the mean number of topics discussed at the last visit varied by the level of confidentiality provided at that visit (i.e., the entire visit was confidential, the visit was partially confidential, or the visit was not at all confidential). We also examined associations between adolescent-reported provision of any confidential consultation (i.e., the visit was entirely confidential or the visit was partially confidential) at the last visit with discussions of specific health topics at that visit by collapsing responses to the confidential consultation question into two categories (the receipt of any confidential consultation vs. the receipt of no confidential consultation) and building multivariate logistic regression models for each of 11 health topics that adolescents reported discussing with their doctor at the last visit. Health topic variables, as presented to respondents in the adolescent survey, included "my weight," "nutrition/diet," "exercise," "vaccines," "issues at home," "issues at school," "sexual health (e.g., puberty, sexual identity, sexually transmitted diseases, pregnancy prevention)," "smoking, drugs, and alcohol," "how I feel about myself (e.g., self-image)," "mental health (e.g., depression)," and "coping with stress." All models were adjusted to account for gender, race/ethnicity, age, and highest adolescent-reported education of mother and father. Adjusted odds ratios and 95% confidence intervals were calculated for each model. Analyses were performed using Stata version 12 (StataCorp LP, College Station, TX) and SPSS for Windows 21 (IBM, Armonk, NY).

Results

Parents

Our parent sample included 500 subjects, of which a weighted majority were female. Approximately two thirds of this population was white, and most reported their age to be between 41 and 64 years. Less than one quarter reported their highest level of education to be high school graduation or less. The sample was fairly evenly distributed in terms of the age and gender of adolescent children (Table 1).

When asked whether a confidential consultation was provided to their adolescent child at the last visit, approximately 16% reported that the entire visit was confidential and an additional 30% reported that at least a portion of the visit was confidential. In cases where some level of confidentiality was provided, slightly less than half said they were not in the examination room because they volunteered to wait outside. Although nearly two thirds said they would prefer to be in the examination room with their adolescent for the entire visit, a sizeable majority agreed that their adolescent should be able to speak with his or her provider alone, and nearly 40% felt that a parent's presence in the examination room would restrict the conversation.

Table 1
Parent sample characteristics[a]

Variables	n (weighted %)
Sociodemographic	
Gender	
Male	203 (43.4)
Female	297 (56.6)
Race/ethnicity	
Black/African-American	99 (11.9)
Hispanic/Latino	59 (17.6)
White	319 (66.9)
Other/mixed race	20 (3.4)
Declined to answer	3 (.3)
Age	
Young adult (18–25 years)	5 (1.0)
Young middle adult (26–40 years)	134 (27.7)
Older middle adult (41–64 years)	346 (69.2)
Older adult (65–77 years)	15 (2.8)
Highest reported education	
High school graduation or less	63 (23.9)
At least some college	310 (60.0)
At least some graduate school	127 (16.0)
Age and gender of adolescent child	
Young adolescent male (13–15 years)	100 (22.4)
Young adolescent female (13–15 years)	100 (21.5)
Older adolescent male (16–17 years)	151 (29.4)
Older adolescent female (16–17 years)	149 (29.8)
Confidential care	
Confidential care provided to adolescent child at last visit	
No	230 (48.5)
Yes, portion of visit confidential	147 (30.1)
Yes, entire visit confidential	98 (15.9)
Do not know/remember	25 (5.5)
If confidential care provided, reason why parent not in examination room	
Volunteered to wait outside	108 (44.1)
Asked to wait outside by physician	58 (24.4)
Asked to wait outside by adolescent	52 (23.3)
Other	27 (8.2)
Prefer to be in examination room for entire visit	
Agree	285 (61.2)
Disagree	215 (38.8)
Believe that adolescent should be able to speak alone with provider	
Agree	447 (88.8)
Disagree	53 (11.2)
Feel that parent presence in examination room restricts conversation	
Agree	224 (39.6)
Disagree	276 (60.4)

[a] N = 500.

Adolescents

Our adolescent population included 504 subjects, of which a weighted majority were male, and most identified as white, Hispanic/Latino, or black/African-American (Table 2). Approximately 60% fell in the older adolescent category of 16–17 years. A small majority reported their father's highest level of education to be high school graduation or less, whereas slightly less than half reported the same for their mother.

Less than half reported the provision of confidential consultation at the last visit, with approximately 10% reporting that the entire visit was confidential and almost 36% reporting that a

Table 2
Adolescent sample characteristics[a,b]

Variables	n (weighted %)
Sociodemographic	
Gender	
Male	252 (51.6)
Female	252 (48.4)
Race/ethnicity	
Black/African-American	78 (14.3)
Hispanic/Latino	67 (20.0)
White	293 (52.3)
Other/mixed race	56 (11.9)
Declined to answer	10 (1.5)
Age	
Younger adolescent (13–15 years)	202 (38.6)
Older adolescent (16–17 years)	302 (61.4)
Highest reported education—mother	
High school graduation or less	206 (45.8)
At least some college	166 (39.2)
At least some graduate school	132 (15.0)
Highest reported education—father	
High school graduation or less	224 (51.5)
At least some college	141 (32.0)
At least some graduate school	139 (16.4)
Confidential care	
Confidential care provided at last visit	
No	239 (51.0)
Yes, portion of visit confidential	154 (35.5)
Yes, entire visit confidential	45 (10.4)
Do not remember	16 (3.1)
If parent in room, believe discussion different if parent not in room	
No	202 (52.4)
Yes	191 (47.6)
If parent not in room, believe discussion different if parent in room	
No	24 (55.5)
Yes	21 (44.5)

CI = confidence interval; AOR = adjusted odds ratio.
[a] N = 504.
[b] There is a demonstrated correlation using multivariate logistic regression between the confidential care variable and both age and gender adjusting for all other demographics (AOR, 1.8; 95% CI, 1.1–3.0 and AOR, .4; 95% CI, .2–.6, respectively).

portion of the visit was confidential. For those who reported that their parent was not in the examination room at all during the visit (i.e., the visit was entirely confidential), nearly half believed the discussion would have been different if their parent was in the room. Likewise, for those who reported that their parent was in the room for at least part of the visit, nearly half believed the discussion would have been different if he or she was not.

Our examination of the mean number of topics discussed per level of confidentiality revealed that the greatest number of topics were discussed when a visit was partially confidential and the fewest number of topics were discussed when a visit was not at all confidential (Figure 1). There was a statistically significant difference between these two groups as determined by one-way analysis of variance ($F[3,449] = 10.35$; $p = 0$). A Scheffe post hoc test revealed that the number of topics discussed was significantly higher when the visit was partially confidential (4.11 ± 3.05; $p = 0$) compared with when the visit was not at all confidential (2.76 ± 2.68; $p = 0$). There were no other statistically significant differences.

Results of the multivariate logistic regression models demonstrated significant associations between the provision of confidential consultation at the last visit and whether a particular health topic was discussed in 8 of 11 instances (Table 3). The only topics that appeared to be unaffected by the provision of confidential consultation were weight, vaccines, and issues at home.

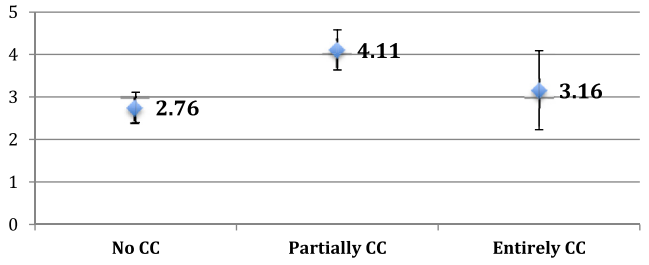

Figure 1. Mean number of topics discussed per level of confidential consultation (CC) provided with 95% confidence interval.

Discussion

Approximately, half of both our parent and adolescent populations reported that at least a portion of the last adolescent preventive care visit was confidential. As expected, the provision of adolescent-reported confidential consultation was significantly associated with both adolescent age and gender (Table 2). These rates and correlations are similar to those found in previous studies of adolescents in the United States [16,17].

Consistent with previous studies of parent beliefs and opinions, our nationally representative sample of parents reported mixed views regarding adolescent confidentiality [12,18]. Although these findings demonstrate that parents may support the provision of confidential consultation in theory, they also suggest that parents may be confused about what confidentiality actually entails and/or uncertain about its importance. It may also be that parents simply feel conflicted. On the one hand, they may want their adolescent to be empowered to speak privately with physicians. On the other hand, they may believe that their adolescent feels comfortable discussing sensitive topics in their presence or they may want to be present so they can intervene if something negative is impacting their adolescent's life. Although more information regarding the underlying source of this

Table 3
Association of confidential care with health topics discussed at last visit as reported by adolescents[a]

Health topics discussed	Confidential care AOR (95% CI)
Self care topics	
Weight	1.1 (.7–1.7)
Nutrition/diet	1.6 (1.0–2.6)[b]
Exercise	1.8 (1.1–3.0)[b]
Vaccines	.8 (.5–1.3)
General issues	
Issues at home	1.8 (.9–3.6)
Issues at school	2.1 (1.1–4.3)[b]
Sexual health and risk behaviors	
Sexual health	2.6 (1.6–4.2)[b]
Smoking, drugs, and alcohol	3.1 (1.9–5.2)[b]
Mental health and wellness	
Self image	2.5 (1.4–4.5)[b]
Mental health	1.9 (1.1–3.6)[b]
Coping with stress	2.2 (1.2–4.0)[b]

CI = confidence interval; AOR = adjusted odds ratio.
[a] Multivariate logistic regression; adjusting for gender, race/ethnicity, age, highest reported education of mother, and highest reported education of father.
[b] Variable achieved statistical significance.

discrepancy is needed, its existence suggests a need for more effective communication with parents about the legal and ethical parameters of adolescent confidentiality and its demonstrated benefits. Some of this parental ambiguity may dissipate if physicians disclose the extent to which they are willing and able to disclose private conversations with adolescents, either to parents or to other entities when required by law.

Nearly half of all adolescents reported that they believed their parent's presence (or absence) in the examination room at the last visit impacted their clinical conversation and our findings specific to the relationships between confidentiality and the number and subject matter of health topics discussed at the last visit certainly support this descriptive observation. The statistically significant difference in the number of topics discussed when a visit was partially confidential versus when a visit was not at all confidential suggests that providing adolescents with an opportunity for confidential consultation, but also inviting the participation of parents, may result in clinical conversations that address a broader array of topics. One explanation for this may be that adolescents and physicians are more likely to broach sensitive topics during the confidential portion of a visit, and parents may raise topics they deem important during the nonconfidential portion, resulting in an increased number of topics discussed overall. In terms of allowing for the richest conversations possible, our findings suggest that a split-visit model, with parents participating for some amount of time before stepping out of the examination room, is the most ideal for adolescent preventive care visits. Explaining the benefits of this model to adolescent patients and their parents at the beginning of a clinical visit may help clarify expectations and boundaries.

Not surprisingly, clinical conversations regarding sexual health were positively correlated with confidentiality, as were conversations related to other sensitive topics including smoking, drugs, and alcohol; self-image; mental health; problems at school; and coping with stress. Although this study underscores the previous work of Ford et al. [4] showing that adolescents are hypothetically unwilling to consult with physicians regarding sexuality, substance abuse, and mental health if confidentiality is not assured and a more recent observational study showing that clinical conversations that explicitly address confidentiality are associated with increased discussions about sexuality [19], it also adds to the field by demonstrating that confidential consultation impacts reports of actual clinical conversations regarding a much wider variety of sensitive topics than previously examined. These topics represent some of the most common causes of adolescent morbidity and mortality, and the delivery of appropriate anticipatory guidance and screening practices is critical to early detection and effective intervention. Failing to provide adolescents with an opportunity for confidential consultation about these topics may ultimately inhibit the delivery of key health care quality components.

The self-care topics of diet, nutrition, and exercise were also significantly correlated with the provision of confidential consultation, suggesting that adolescents may be uncomfortable talking about these issues in the presence of their parents as well. In light of these new findings, it may be clinically beneficial for physicians to broach self-care topics, at least initially, in a parent's absence. Although we anticipated a similar finding for weight, we found no such relationship. This may be because of the systematic way weight is assessed and addressed at preventive care visits [20]. Of note, there was also no significant association between confidentiality and discussions about issues at home—perhaps, because this is a topic that a parent or adolescent may be equally likely to raise.

Interestingly, the only other topic of discussion that did not vary significantly with confidentiality was vaccines. This may be because most routine vaccines are administered during the preadolescence period, rendering them irrelevant for our study population. In the case of human papillomavirus vaccine, which remains controversial, it may also be that physicians are averse to discussing the subject at all.

In interpreting the findings of this study, it is important to note their potential limitations. First, the secondary nature of this research resulted in our not being able to calculate response rates. Although Harris Interactive weighted the data from both surveys to be nationally representative, we cannot be certain that some subtle selection bias was not present. Furthermore, this is a study of self-reported survey responses and we have no way of verifying that they are accurate. For example, it is possible that respondents failed to remember the details of the last visit or that they altered them in some significant manner. It is also possible that parents may have altered reports of educational achievement for social desirability reasons or that adolescents may not have been aware of the finer details of their parents' educational achievements.

This study suggests that structuring preventive health care visits in a manner that provides adolescents with an opportunity for confidential consultation, but also invites the participation of parents, may result in clinical conversations that address a greater number of important topics. Such a split-visit arrangement may also have the benefit of appealing to parents who have mixed feelings about the provision of confidential consultation to their adolescent. Findings from this study also demonstrate that confidentiality significantly impacts the subject matter of clinical conversations. These findings are particularly important in regard to discussions about sexual health, mental health, and substance use—issues that underpin a majority of adolescent morbidity and mortality in the United States. This study adds weight to a growing body of research that makes a strong legal, ethical, and clinical case for the consistent provision of confidential health care services, including confidential consultation, to adolescents. As the ACA is fully implemented and the number of adolescents accessing preventive health services increases, it is important that emerging policies reflect these findings.

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