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Original article

Adolescents Spending Time Alone With Pediatricians During Routine Visits: Perspectives of Parents in a Primary Care Clinic

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A B S T R A C T

Purpose: To increase understanding of parental perspectives on time alone and of factors that influence adolescent communication with physicians in a pediatric clinic.
Methods: The sample consisted of 91 parents of adolescents aged 14–17 years who attended a well child visit at one primary care pediatric practice and completed a 2-week follow-up phone call as part of a larger study on adolescent health and communication. Parents reported whether their child met alone with the pediatrician, rated the importance of him or her having time alone with the physician, and responded to open-ended questions regarding barriers and facilitators of adolescent-physician communication. Bivariate and multivariate analyses tested associations of parent and adolescent characteristics with perceived parental importance of time alone. We conducted content analyses of responses to open-ended questions.
Results: Slightly more than half of parents (n = 53, 58%) indicated that it was "a lot" important for their adolescents to meet alone with the pediatrician; parents of males were more likely than parents of females to select this highest rating (73% vs. 43%, $\chi^2(1) = 8.34$, $p = .004$; adjusted odds ratio 4.88, 95% confidence interval 1.84–12.96). Responses to open-ended questions identified numerous adolescent, parent, and provider factors that parents perceived to influence adolescent-physician communication during well child visits, such as preparation for visit, rapport and familiarity with the pediatrician, privacy concerns, time alone with the pediatrician, emotional comfort, trust, and support.
Conclusions: Most parents thought time alone was highly important for their own adolescent in a primary care setting, and parents described additional strategies to facilitate adolescent communication.

IMPLICATIONS AND CONTRIBUTION

The majority of parents perceived time alone for their own adolescent in a pediatric setting as important, and described multiple additional adolescent, parent, and provider factors that may influence adolescent communication with physicians during well child visits. Future research is needed to reduce barriers to time alone and to enhance communication.

Professional organizations have supported developmentally appropriate confidential adolescent health care within ethical and legal guidelines for more than 25 years [1–4]. The rationale for adolescents having access to time alone with physicians includes supporting adolescents' emerging autonomy, facilitating the development of the adolescents' skills to manage their own health, and increasing physician-adolescent communication about

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sensitive health topics [5]. Research has shown that adolescents are more likely to seek health care and openly talk to physicians when they are assured of privacy, particularly for issues related to sexual behaviors, substance use, and mental health [6–8].

Despite recommendations, less than half of adolescents report time alone with clinicians during preventive visits [8,9]. Managing parental expectations is one challenge that clinicians face with respect to time alone with adolescents, particularly in primary care settings [10]. Prior research on parental perspectives regarding confidential adolescent health care has found that parents have conflicting attitudes. For example, in a nationally representative survey in the United States, 61% of parents of adolescents 13–17 years old preferred to be in the examination room the entire time their adolescent was being seen for a preventive visit; at the same time, 89% of parents believed that adolescents should be able to speak alone with providers [8]. Another study found that parents were able to identify benefits associated with confidential care yet also believed they should be informed about a wide range of topics, even if their children did not want them to know [11]. One qualitative study found that mothers had substantial concerns about clinicians having confidential discussions about sex with their daughters [12].

Recommendations for time alone must be placed within a broader context that recognizes the rationale for supporting multiple strategies for facilitating adolescent-physician communication. Effective communication with adolescents is important with respect to visit satisfaction [13], adherence to treatment recommendations [14,15], perceptions of control and competence [16], and decisions to seek future health care [17]. However, communicating with adolescents may be challenging for multiple reasons, including perceived adolescent lack of interest [18], a longstanding pattern of parents as the primary focus of communication [18], and physician self-efficacy regarding effectively engaging adolescents [18].

Most adolescents are seen for preventive care in primary care clinics, with parents present, and efforts to improve population-based adolescent health through clinical service delivery must include efforts to assure high-quality adolescent-physician communication and developmentally appropriate confidential care [19]. To date, parent-focused research on this topic has been conducted outside of the clinical context or in highly specialized clinics [8,9,11,20]; the few pertinent studies in primary care settings have involved focus groups and were not conducted in the context of actual well-child care [12]. As part of a larger study on parent-teen communication and adolescent health, we explored parents' perspectives of their own adolescents spending time alone with pediatricians in a primary care practice as part of routine well child visits (WCVs). Our goals were to examine (1) whether time alone and perceived importance of time alone were associated with the adolescents' age, race, and sex and parental education; (2) parents' perceptions of factors that hinder or facilitate their adolescent's communication with the pediatrician during WCVs.

Methods

Overview

This study used data from a randomized controlled trial (NCT02554682) examining a parent-directed intervention to improve parent-adolescent communication about sexual health, alcohol use, or teen driving in adolescents aged 14–17 years. Specifically, participants in Arm 1 were ages 14–15 years old and were randomly assigned to receive usual care (control), the sexual health intervention, or the alcohol intervention. Participants in Arm 2 were ages 16–17 years and planning to apply for their driver's permit; these participants were randomized to receive usual care (control) or the teen driving intervention. All intervention participants received a general handbook related to adolescent development and parent-adolescent communication, as well as materials specific to their intervention group. Intervention content did not focus on confidential care or physician discussion of sensitive health topics with adolescents. For this analysis, we used 2-week follow-up data collected from parents who were assigned to one of the intervention groups.

Recruitment and participants

Participants were recruited from January 2016 to September 2016 from one urban primary care practice in the Pediatrics Research Consortium at Children's Hospital of Philadelphia (CHOP). The practice has 13,411 enrolled patients (7,201 [54%] ages 0–9 and 6,210 [46%] ages 10+) and provided 27,635 visits in the last year (13,207 [48%] WCVs and 14,428 [52%] acute visits). Providers see 11–12 patients per half-day clinic session and are allotted 15 minutes for WCVs. Eligible participants included adolescents between 14 and 17 years with a scheduled WCV, identified from CHOP's electronic medical record system, and one parent or legal guardian. Adolescents who were pregnant, were not an established patient, or had a developmental delay or pervasive developmental disorder that would prevent him or her from completing study procedures were ineligible. Letters were mailed to parents 1–2 months before the scheduled WCV and directed parents to contact the study team. Phone calls were placed to all parents who did not contact the study team.

A total of 425 parent-adolescent dyads were contacted and screened. Of these, 188 (44%) did not meet eligibility criteria, 26 (6%) declined, and 37 (9%) could not be scheduled or reached again. The final enrolled sample consisted of 174 participant dyads. A comparison of this sample with those who were contacted but did not participate showed that they did not differ with respect to adolescent age, sex, race, or ethnicity ($ps > .10$). Of the 174 enrolled dyads, 108 were assigned to one of the intervention groups and eligible to complete the 2-week follow-up (parents in the control groups did not complete the 2-week follow-up assessment). Of these, 91 (84%) parents completed the follow-up. Those who completed the 2-week follow-up were not different from those who did not with respect to intervention arm or adolescent age, sex, race, or ethnicity ($ps > .10$).

Procedures

The institutional review board at CHOP approved the study protocol. During the recruitment call, study personnel explained the study to the parent and adolescent, and obtained parental consent and adolescent assent. Dyads were randomized into study groups, completed a baseline assessment, and attended the adolescent's WCV. For the present analysis, we focused on data obtained from parents at the 2-week follow-up call. Responses were entered directly into Research Electronic Data Capture [21], a secure, web-based application designed to support research data capture. Parents received $5 for completing the 2-week follow-up.