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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.
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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.

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.

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