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Confidential Consultations With Adolescents: An Exploration of Australian Parents' Perspectives

Rosemary A. Sasse, M.B.B.S. [a,b], Rosalie A. Aroni, Ph.D. [a], Susan M. Sawyer, M.B.B.S., M.D. [b,c,d], and Rony E. Duncan, Ph.D. [b,c,*]

[a] Department of Epidemiology and Preventive Medicine, School of Public Health and Preventive Medicine, Monash University, Melbourne, Victoria, 3004 Australia
[b] Centre for Adolescent Health, Royal Children's Hospital, Parkville, Victoria, 3052, Australia
[c] Murdoch Childrens Research Institute, Parkville, Victoria 3052, Australia
[d] Department of Paediatrics, The University of Melbourne, Parkville, Victoria 3010, Australia

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A B S T R A C T

Purpose: Extensive literature documents the high value adolescents place on seeing doctors alone for confidential health care. This is articulated in clinical guidelines that promote confidentiality for adolescents. However, little research has explored parents' views and beliefs regarding their adolescent children seeing doctors alone for confidential care.
Method: A qualitative study was undertaken to investigate the beliefs and opinions of parents about confidential care for adolescents. In-depth semi-structured interviews were conducted with 17 parents of adolescents recruited through the Centre for Adolescent Health at the Royal Children's Hospital in Melbourne, Australia. Interviews were audio-recorded and transcribed verbatim. Transcripts were analyzed using content and thematic analyses.
Results: Parents demonstrated a wide variety of opinions about confidentiality for adolescents in the health setting, with several expressing concern about not being involved in their children's care. Parents' opinions appeared to be underpinned by two key factors; the way in which they perceived their role as a parent and the level of trust they held in health professionals generally but also, specifically, their child's doctor.
Conclusion: In this study, parental desires regarding confidentiality for their adolescent children in the health setting were not always in accordance with current guidance provided to health professionals. Consequently, the provision of confidential care for young people may be more successful if health professionals invest in building trust with parents, as well as with adolescents, to facilitate parental acceptance of confidential health care for adolescents.

IMPLICATIONS AND CONTRIBUTION

This research suggests that some parents of adolescents would find current recommendations regarding confidential consultations with young people challenging because they view these as a threat to their parental role. Such knowledge can be used by clinicians to build trust with parents, facilitating their role in caring for their children while also promoting confidentiality for adolescents.

Confidentiality for adolescents in the medical setting is a key aspect of high-quality health care [1–4]. To achieve confidentiality between adolescents and health professionals, one-on-one conversations without parents present (confidential consultations) are recommended by guidelines internationally [5–8]. Evidence demonstrates that young people highly value assurances of confidentiality, which strongly influence both their attendance at medical services and their willingness to confide in doctors [2,9–11]. Confidential consultations are also understood to promote adolescent autonomy and independence [6] and are grounded in the ethical and legal principles of consent, competence, and confidentiality [12].

Parental expectations and understandings regarding confidential consultations for young people have not been well-documented

* Address correspondence to: Rony E. Duncan, Ph.D., Centre for Adolescent Health, Level 2, Royal Children's Hospital, 50 Flemington Rd, Parkville, 3052, Australia.
E-mail address: rony.duncan@mcri.edu.au (R.E. Duncan).

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[13]. What research is extant suggests that despite being able to identify a range of potential benefits associated with confidentiality for young people, parental views are mixed, and parents are often uncomfortable with the idea of confidential care for their own children [14–18]. Research has indicated that parents often want to be informed about matters discussed confidentially and can view the receipt of such information as a parental right [15,19,20]. Currently, what underpins these views is not well-understood, yet these underpinnings are nevertheless acknowledged as multifaceted and complex [15,16,20]. To date, only two studies have qualitatively explored parental understandings of confidentiality in depth and both have used focus groups with Latino parents in the United States [14,15]. Both studies highlight a range of parental concerns about confidentiality for adolescents, with the study by Tebb and colleagues [15] also finding a variety of factors that influence parental acceptance of confidential consultations. However, it is not clear to what extent these findings are exclusive to Latino parents or whether they translate to other populations of parents throughout the world.

The current study aimed to investigate the beliefs of Australian parents of adolescents regarding confidential consultations for young people. The study was motivated by findings from our previous quantitative survey, which identified that Australian parents held conflicting views about confidentiality [21]. Parents were able to identify several positive aspects of confidential care for young people, yet were simultaneously concerned about not being informed of important issues. Many also indicated a desire to be informed about a wide range of sensitive topics following a confidential consultation between their adolescent child and the doctor, even if their child did not want them to know. This research was unable to elucidate the reasons behind parents' views, which is necessary information if clinicians are to adequately support parents as well as adolescents. Therefore, the current study set out to gain insight into the beliefs that underpin parents' views around doctors seeing their adolescent children alone for confidential consultations.

Methods

A qualitative methodology was chosen to facilitate investigation of the complexity underlying parental opinions regarding confidential care for their adolescent children. Parents of adolescent patients attending the Centre for Adolescent Health (CAH) at the Royal Children's Hospital in Melbourne were approached in the waiting room and invited to participate in a single semi-structured in-depth interview about their views on confidential consultations between adolescents and doctors. Interested parents were provided with a plain-language statement and consent form and were then contacted within a week by telephone to arrange individual audio-recorded interviews of approximately 30–60 minutes. In this specialist adolescent medicine setting, medical consultation with parents and young people together is generally followed by a confidential consultation with the young person alone, followed by a regrouping with the parent at the end of the consultation. Parents were recruited from clinics including Adolescent Medicine, Chronic Fatigue, Eating Disorders, General Mental Health, and Respiratory Medicine. The inclusion criterion simply required participants to be a parent of an adolescent attending the CAH. The sole exclusion criterion was an inability to communicate verbally in English, as funds were not available for interpreters.

Recruitment occurred in the second half of 2011. Sampling was initially consecutive (based on the availability of author R.A.S.), based on the assumption that this would allow for the potential inclusion of all parents attending the CAH within the timeframe of the study and hence yield a sample of wide variation. When this variation did not eventuate, however, purposive sampling was adopted to achieve greater variation regarding the child's age and presenting problem, a sampling strategy that is recognized as often providing the best means to gain access to a wide and information-rich range of cases [22].

Interviews were conducted with 17 parents (15 mothers, 2 fathers), at the parents' home or, in the case of five rural parents, by telephone. Participant demographics are summarized in Table 1. Seven parents were excluded from the study as a consequence of not being able to communicate verbally in English. The semi-structured interviews covered several key themes, including: parents' past experiences with confidential consultations for their children; parents' views on young people seeing doctors alone for confidential care; the amount and type of information that doctors should share with parents; and parents' opinions about what might make them feel more comfortable with confidential consultations for their children. All interviews were conducted by author R.A.S. and transcribed verbatim. Verbatim transcripts were used for

Table 1
Participant demographics

Parent pseudonym	Age (years) & gender of index child	Reason for child's attendance	Age (years) of any other children in the family
Anne, mother	18, daughter	Eating disorder	20
Carol, mother	17, daughter	Eating disorder	22, 20, 15
Kay, mother	16, daughter	Eating disorder	24, 22, 21
Catherine, mother	15, son	Eating disorder	13
Mary, mother	14, daughter	Eating disorder	12, 10, 6, 4
Oliver, father	16, daughter	Eating disorder, Personality disorder	14
Lily, mother	17, son	Depression	20
Diane, mother	16, daughter	Complex multi-organ congenital syndrome	11
Imogen, mother	13, daughter	Mental disorder and gynecological issues	23, 20, 17
Madelaine, mother	15, daughter	Gynecological issues	23, 21, 17
Pamela, mother	16, daughter	Chronic Fatigue Syndrome, Polycystic Ovarian Syndrome	None
Gail, mother	16, son	Chronic constipation	18, 17, 12, 9
Naomi, mother	17, daughter	Cardiac issues	21, 20, 19, 16, 14, 13, 11, 7, 6
Natasha, mother	16, daughter	Chronic Fatigue Syndrome	18, 17, 14, 8
Julia, mother	18, daughter	Gynecological issues	21
Arthur, father	16, son	Type 1 Diabetes Mellitus	18, 16, 14, 12
Donna, mother	18, son	Asthma	28, 25, 18