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Editorial

Which Adolescents Have Opportunities to Talk to Doctors Alone?

The importance of confidential adolescent health care has been explicitly acknowledged by all major health professional organizations for nearly two decades [1,2]. Private conversations between adolescent patients and health care professionals are developmentally appropriate as children transition through adolescence into young adulthood, because adolescents need to learn skills to become increasingly responsible for their own health and health care. Private conversations with a health care professional also allow discussion of topics or behaviors that adolescents may not disclose or discuss in the presence of a parent. Research has consistently shown that adolescents' concerns about privacy can delay or prevent some adolescents from seeking health care, and interfere with open patient-physician communication about issues that need to be discussed because they have a major impact on adolescent health such as sexual behaviors, substance use, and mental health [3–18].

Despite the acknowledged importance of providing opportunities for private adolescent patient–clinician discussions, existing research shows that this does not occur as frequently as one might hope or expect. Two articles in this issue of the *Journal of Adolescent Health* make important contributions to a growing literature that describes which adolescent patients do not get private time with a health care professional, and why. Edman et al report results of secondary data analyses using the Medical Expenditure Panel Survey Child Health Supplement, which provides national estimates of health care delivered across the United States [19]. For these analyses, office records were used to determine whether adolescents between 12 and 17 years of age had been seen for routine preventive visit in the past 12 months, and caregiver interviews were used to determine whether the adolescent had spent any time alone with their healthcare provider during their most recent visit. Results show that adolescents aged 12–17 years who had a preventive visit in the previous year were more likely to have spent time alone with a clinician at their last visit than adolescents without a preventive visit. Nonetheless, even among adolescents aged 12–17 years who had an annual preventive visit, the minority (40%) had time alone with a clinician at their last visit. Young, female, and Hispanic adolescents were less likely to spend time alone with a clinician at their last visit as compared to older, male, and non-Hispanic adolescents. The highest proportion to receive time alone with a clinician at their last visit was among 17-year-old adolescents, and that proportion was barely above one-half (57%).

O'Sullivan et al report the results of an innovative study conducted in selected communities in New York during which healthcare professionals were asked to report their own practice behaviors immediately after 215 adolescent (aged 12–18) patient visits [20]. Of the 144 visits attended by a parent, clinicians reported that 68% involved time alone with the adolescent patient. Clinicians also reported that they on an average spent 51% of the visit privately and parents responded extremely well to being asked to leave the room. Adolescents were more likely to spend time alone if they were being seen for a scheduled physical, and if they presented with a problem that could have been related to sexual health.

Taken together, these articles raise important issues. First, reasons that an adolescent patient does or does not have the opportunity to talk privately with a healthcare professional appear linked to reason for visit. Future research will benefit from measuring predictors and characteristics of adolescent patients' time alone with clinicians during specific types of visits. Second, whether an adolescent spends time alone with a clinician appears to vary by patient characteristic and research is needed to understand why. Why are young adolescent girls less likely to have opportunities to talk privately with clinicians as compared to young adolescent boys? Why are Hispanic adolescents less likely to have opportunities to talk privately with clinicians as compared to non-Hispanic adolescents? Third, these articles are consistent with the published data showing that opportunities for private adolescent patient–clinician discussions are not occurring as frequently as one might hope or expect.

Whether an adolescent patient spends time alone with a healthcare professional in many situations can affect quality of health care. The U.S. Preventive Services Task Force, based on strong evidence-based reviews, recommends high-intensity behavioral counseling to prevent sexually

See Related Article p. 393

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transmitted infections among sexually experienced adolescent boys and girls, and has specific testing recommendations for chlamydia, gonorrhea, and HIV that depend on level of risk [21]; clinicians need to be able to obtain an accurate sexual history to determine level of risk, and their ability to do so will be hampered if questions about adolescent sexual behaviors are asked in the presence of a parent. Similarly, the U.S. Preventive Services Task Force has also recently recommended screening adolescents aged 12–18 years for major depressive disorder, and accurate assessments of depression may be more likely when adolescent patients and clinicians have the opportunity to talk privately. Future research should also identify strategies to ensure that all adolescents receive the private time needed with healthcare professionals to facilitate high-quality adolescent healthcare services.

Carol A. Ford, M.D.
Associate Professor
School of Medicine
Gillings School of Global Public Health
University of North Carolina at Chapel Hill
Chapel Hill, North Carolina

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