



Editorial

Opportunities to Improve Adolescent Health and Wellbeing Through Medical Education and Delivery of Quality Preventive Care



In this issue of the journal, Al-Shimari et al. report on clinicians' time alone with adolescent patients during routine healthcare visits in 10 primary care clinics in Washington State [1]. Their secondary analysis of adolescent well visits from two randomized controlled trials of electronic health risk behavior screening feedback found a wide variation in whether young people had private, one-on-one time with their clinicians during visits. The percent of adolescents who reported having had time alone during their visit varied from 51.6% to 97.8% across their study sites. Comparing the performance of individual clinicians at these sites, some saw none (0%) of their adolescent patients alone, and some saw all of them (100%) alone during their visits. Adolescents who reported engaging in sexual activity were more likely to have received time alone; those reporting substance use, disordered eating, or having a positive depression screen or suicidal ideation were no more likely to report having received time alone than those not reporting these behaviors. Older adolescents and males were also more likely to report time alone compared to females or younger teens and there was no association between race or ethnicity and time alone in their study.

Primary care guidelines universally and consistently recommend that adolescents have an opportunity for confidential screening and counseling to prevent risky behaviors and promote healthy behaviors. Confidentiality encourages adolescents to seek healthcare for sensitive concerns and to disclose information about their health-related behaviors to their clinicians. In addition, without it, many adolescents forgo needed care [2,3]. While the periodicity and frequency of visits and the exact services recommended vary slightly across primary care disciplines, the basic structural and process recommendation is consistent, and the importance of confidentiality is, for the most part, noncontroversial. And yet, this study, and others [4], continue to find wide variation in clinicians' delivery and adolescents' receipt of these recommended interventions.

In previous work, we have explored a triadic model, recognizing the complex relationship between parents, adolescent patients, and clinicians [5]. Parents select how and where most adolescents get routine healthcare, and this model reflects the partnership parents expect with pediatricians, family physicians, or other clinicians caring for their teens. Parents and their adolescent often agree on what should be addressed

confidentially, and on the importance of preventive care [6], although young people are slightly more likely to value privacy, especially for sexuality and risky behaviors, and parents are more likely to value prevention. Parents also desperately want to keep their adolescents and young adults safe and they choose their family's clinicians because they trust us to help them. Not only are parents our partners but they also are the primary and most significant influence on their teens' attitudes and behaviors.

The American Medical Association's Guidelines for Adolescent Preventive Services, first published 28 years ago, is a direct precursor of the US Public Health Service and the American Academy of Pediatrics' Bright Futures guidelines adolescent preventive care content. The American Academy of Family Physicians has similar policies about confidential counseling and screening. Early implementation research with the Guidelines for Adolescent Preventive Services found that parents wanted clinicians to address behavioral risks and sexuality issues, but they did not think we clinicians were very good at it [7,8]. Nearly a generation has passed, and it is highly likely that every single one of the clinicians in Al-Shimari's study could tell you why it is important for adolescents to be seen confidentially. But then, why don't they do it?

In residents' continuity clinic and even in adolescent medicine practice, I often hear trainees and their preceptors talk about needing to "kick the parent out of the room". There are certainly alternative ways to describe the critically important process of having time together and time alone with adolescents and I believe the choice of words here matters. Kicking parents out versus always seeing teens both alone and with parents send very different messages about the value we place on the role parents and other caring adults play in young peoples' lives. By "kicking", we may send a mixed message to trainees, even if we explain it well to families—leaving too many trainees without having learned the skills to do this comfortably or well in their future practices.

Over the past few decades, advocacy has been recognized as a core competency of pediatric training. We advocate for the environment, for gun safety, and for reproductive health and rights—all critically important issues. But how successfully have we advocated for adolescent care expertise, for effective preventive care training in health professionals' training, for

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inclusion of confidential time alone as a quality measure for health insurers and delivery systems, or for parents to ask for clinicians to appropriately spend private time with their teens during adolescent well visits? Adolescent health professionals have been consistent and strong advocates for confidential access, so that adolescents may be seen alone when needed, for reproductive care, abuse or neglect, substance abuse, and mental health. In the current political environment, access to confidential reproductive health services becomes even more important, as the U.S. Supreme Court moves many U.S. states closer to eliminating access to abortion and threatening access to birth control. But we also need all clinicians to determine when confidential private time within a visit is needed and partner with parents and families to advocate for and deliver this as an essential component of quality adolescent healthcare. If we really want to promote wellbeing and effective prevention for young people, adolescent health advocates needs to address this from all sides: public health/health promotion, quality and accountability measures, medical education, and clinical care.

Not surprisingly, Al-Shimari found that reproductive health needs more often led to confidential, one-on-one counseling. This raises questions about whether this is due to differences in how sexual behavior is screened for, the ability to respond with highly effective interventions, or the greater awareness of clinicians to sexuality-related needs, compared to substance use or mental health issues. Their call for more research to understand the factors affecting this variation is valid, ideally along with implementation studies to demonstrate effective integration, spread, and accountability for better screening and counseling processes in primary care. But advocacy for greater integration of adolescent health into clinical preventive care education and practice and greater accountability for health systems and payers does not need to wait for this evidence. The World Health Organization's PMNCH (Partnership for Womens' Childrens' and Adolescents' Health), a global alliance of more than 1,250 international agencies, governments, and civil society organization organizations, has issued a call to action for adolescent wellbeing [9]. The call to action seeks engaged youth; whole of government, not just health, commitments to youth-serving programs; data and accountability; and increased political and financial

commitments by governments. The evidence base and the business case for these investments will be seen in the literature in the coming months. Global professional organizational members of PMNCH, including the International Association for Adolescent Health, the International Pediatric Association, and others, are working to support evidence-based advocacy by adolescent and child health leaders to encourage all governments to make these needed commitments to adolescent health and wellbeing. Al-Shimari's article reminds us that there is much we can do right now to improve adolescent health education and training, and to improve health systems and the quality of care delivered to young people. We have both the opportunity and the obligation to do so without delay.

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