Adolescent Preferences for Topics Addressed During Well Visits

Eugene C. Lee, MD

ABSTRACT

Background: Current evidence is limited regarding the topics adolescents want to discuss with clinicians during routine well visits. High school students were surveyed to determine potential adolescent discussion topics, barriers to discussion, and ways to promote dialogue.

Methods: Surveys were distributed between October 2014 and January 2015 to 102 students in the Verona Area High School in Verona, Wisconsin.

Results: Of the topics presented, teens preferred to discuss vaccines and mood/stress with their clinicians. Young women were more likely to prefer gender congruent clinicians, especially when discussing sex or body image. The majority of teens felt that information discussed with their physician would be revealed to parents or the authorities.

Conclusions: In limited time with teens, it is important for clinicians to reinforce confidentiality to gain their trust. Clinicians can improve rapport with adolescents by revealing information about themselves, conveying genuine caring, and considering community involvement. Male clinicians need to work on improving rapport, especially when talking with female adolescents about sex, body image, stress, and mood. Clinicians should consider including mood, stress, and vaccine discussions in their adolescent well visits.

INTRODUCTION

The American Academy of Pediatrics (AAP) recommends that adolescents have a preventive visit yearly,[1] however 1 study estimates that only 40% of adolescents between ages 13 and 17 have a yearly preventive visit, while 33.3% of adolescents between the ages of 13 and 17 do not have a yearly visit at all.[2] Another study found that preventive visits declined in middle to late adolescence compared to early adolescence.[3] Furthermore, it is estimated that only 33.3% to 40% of children get the indicated preventive care or anticipatory guidance during their preventive visit.[4,5]

Bright Futures, an AAP-led health promotion and prevention initiative, estimates that a child preventive care visit lasts 28 to 30 minutes, with the physician spending an average of 17 to 20 minutes with the patient.[1] Clinicians have the opportunity to engage adolescents in their own health, but currently there are insufficient recommendations for how clinicians can do so.

Goldenring and Cohen initially derived a mnemonic for clinicians to use as a general guideline for topics to discuss with teenagers: HEADSS - Home, Education, Activities, Drugs, Sex, Suicidality.[6] This mnemonic has expanded to HEEADSSS to include Eating and Safety. Yet, regarding several of those topics, the US Preventive Services Task Force has insufficient evidence to support screening for those issues in teenagers. See Table 1 for Grade A and B recommendations for adolescents.[7]

Adolescents might not want to discuss HEEADSSS topics with their clinicians. Every adolescent is different, but common adolescent discussion topics should be identified. The purpose of this exploratory study was to determine what topics and approaches teens preferred in hopes of improving clinician guidance and rapport between clinicians and adolescents.

METHODS

Population: Students in 3 classes at Verona Area High School (VAHS) in Verona, Wisconsin were surveyed at 2 different times with an anonymous questionnaire regarding several topics. The

• • •

Author Affiliations: University of Wisconsin Department of Family Medicine and Community Health, Madison, Wis; Department of Family Medicine, Loyola University Medical Center, Maywood, Ill.

Corresponding Author: Eugene C. Lee, MD, University of Wisconsin Department of Family Medicine and Community Health, 1100 Delaplaine Ct, Madison, WI 53715; phone 224.622.3277; fax 608.263.5813; e-mail eugenecllee@gmail.com.

CME available. See page 214 for more information.

classes included 2 sections of "Principles of Biomedical Science" and 1 section of "Biotechnology." The students in the Principles of Biomedical Science remained the same, while the students in the Biotechnology class differed between the 2 surveys. These classes consisted mainly of freshmen and sophomores with few juniors and seniors. The students at VAHS come from the southwest portion of Madison, Fitchburg (a suburb of Madison), and Verona (a suburb of Madison that used to be a farming community). In September 2014, 27.7% of the students at VAHS classified themselves as nonwhite.

Table 1. Grade A&B US Preventive Services Task Force and Category A Advisory Committee on Immunization Practices Recommendations for the Nonpregnant Adolescent

Grade/ Category	Recommendation
A	Folic Acid: Supplementation – All women planning or capable of pregnancy
A	HIV: Screening – Adolescents (starting at 15 years old) and adults
A	Syphilis: Screening – Men and women at increased risk
A	Tobacco Smoking Cessation: Behavioral interventions – pregnant women
A	Vaccines: human papillomavirus (HPV), Tdap, meningococcal, influenza
B	Chlamydia: Screening – Sexually active women
B	Depression: Screening – Adolescents aged 12-18 years
B	Gonorrhea: Screening – Sexually active women
B	Hepatitis B: Screening – Nonpregnant adolescents and adults at high risk
B	Intimate Partner Violence: Screening – Women childbearing age
B	Obesity: Screening – Children and adolescents aged 6-17 years
B	Sexually Transmitted Infections: Behavioral counseling – Sexually active adolescents and adults
B	Skin Cancer: Behavioral counseling – Children, adolescents, and young adults aged 10-24 years
B	Tobacco Use: Primary care interventions – Children and adolescents

Survey Instrument: The initial questionnaire consisted of 10 questions designed to determine if clinician interaction with adolescents in a classroom might improve: (1) comfort level in speaking with clinicians about adolescent topics, and (2) human papillomavirus (HPV) vaccination rates. Because HPV vaccination rates were determined to be above Wisconsin's averages in the first survey (73.6% of participants had begun the HPV series and Wisconsin's 2015 at-least-1-dose HPV vaccination rate averaged approximately 45% for 13 to 18 year olds[8]), this portion was not focused on in analysis. The second questionnaire consisted of 12 questions and elaborated on topics from the initial questionnaire. The questionnaires can be viewed in the Appendix, available online at https://www.wisconsinmedicalsociety.org/_WMS/publications/wmj/pdf/116/4/WMJ%20116no4_Lee_Appendix.pdf. Paper questionnaires were distributed to all students present in class that day.

This survey was exempt from institutional review board review as it did not constitute research defined under 45 CFR 46.102(d).

RESULTS

The study population, shown in Table 2, remained consistent between the surveys (P <0.05), so no distinction was made between the 2 survey groups. The majority of teens surveyed had a physician who shared the same gender. Female teens preferred female physicians (93.3%), whereas only 28.6% of males preferred a male physician (P <0.005). Topics where gender congruency mattered are shown in Figure 1. More than 50% of the surveyed adolescents preferred discussing body image and sex with a gender-congruent clinician. Close to a third of teens felt that the congruency of clinician gender mattered in discussing depression, anxiety/stress, and sexuality.

Topics within the HEADSS mnemonic, additional topics of interest determined by the investigator, and teenager preference for learning about those topics are included in Table 3. Some students preferred multiple ways to learn about topics. The 2 topics most adolescents (>70%) preferred to discuss with physicians were vaccines and mood/stress, which included anxiety and depression. Write-in topics from teens included obesity, steroids, and cutting.

Table 2. Study Population

	Male (%)	Female (%)	Other (%)
Survey 1 (n = 53)	18 (34.0)	34 (64.2)	1 (1.9)
Survey 2 (n = 46)	14 (30.4)	30 (65.2)	2 (4.3)
Clinician is same gender as patient	9 (64.3)	24 (80.0)	0 (0.0)
Patient prefers same gender clinician	4 (28.6)	28 (93.3)	0 (0.0)

The majority of teenagers (86.8%) surveyed talk about topics with friends. Additionally, 49.1% of teens would talk with parents or older family members, and 37.8% said they would talk with cousins or siblings. Medical professionals rank fourth at 34.0%, followed by school officials and religious leaders (tied at 17.0%). Students are least comfortable (5.7%) with civil service agents like police officers and firefighters.

In the free response area, teenagers noted being more likely to discuss topics with their physician if there was an assurance of confidentiality and privacy. In response, teenagers were asked about doctor-patient confidentiality and their understanding of confidentiality. When asked if clinicians requested that their parents leave the exam room during a general check-up, 45.7% of students stated yes and 10.9% of students said that it depends on the situation.

Table 4 shows what topics adolescents thought clinicians would keep confidential from parents and the police. The majority of teens indicated that if there was harm to themselves or others, that physicians would inform their parents or authorities. Several teens felt that physicians are required to inform the police if they revealed that they drank alcohol, smoked cigarettes, or used drugs.

Figure. Percentage of Teens Per Topic Where Clinician Gender Congruency Matters

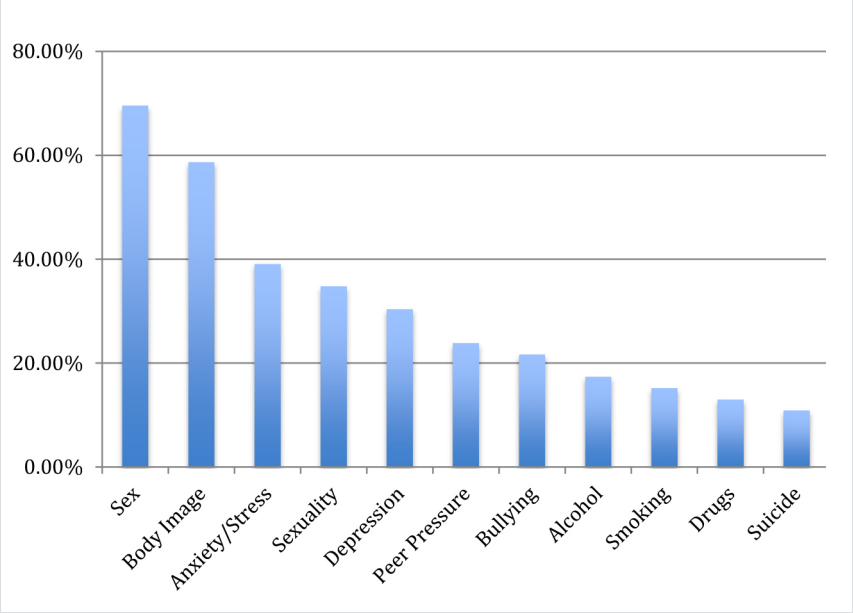

Table 3. Ways Teenager Prefer to Learn About Certain Adolescent Topics, N=53

	Teens Who Prefer to Discuss With a Physician (%)	Teens Who Prefer to Discuss With Another Person (%)	Teens Who Prefer to Self Learn (%)
Vaccines	44 (83.0)	8 (15.1)	3 (5.7)
Mood/stress	38 (71.7)	25 (47.2)	9 (17.0)
Drugs	24 (45.3)	26 (49.1)	20 (37.7)
Alcohol	21 (39.6)	19 (35.8)	23 (43.4)
Smoking	21 (39.6)	22 (41.5)	16 (30.2)
Sex	18 (34.0)	24 (45.3)	16 (30.2)
Peer pressure	14 (26.4)	24 (45.3)	17 (32.1)
Suicide and death	12 (22.6)	27 (50.9)	8 (15.1)
Bullying	8 (15.1)	23 (43.4)	14 (26.4)
Sexuality	6 (11.3)	12 (22.6)	20 (37.7)
Sexting	5 (9.4)	13 (24.5)	17 (32.1)
None	1 (1.9)	6 (11.3)	11 (20.8)

Table 4. Topics Teens Felt Would Not Remain Confidential if Disclosed to Their Physician, N=46

	No. Students Who Believe Physicians Must Inform Parents (%)	No. Students Who Believe Physicians Must Inform Police (%)
Going to hurt yourself	43 (93.5%)	24 (52.2%)
Going to hurt someone else	42 (91.3%)	42 (91.3%)
In danger	42 (91.3%)	Not asked
Using drugs	23 (50.0%)	14 (30.4%)
Drinking alcohol	18 (39.1%)	6 (13.0%)
Smoking cigarettes	16 (34.8%)	5 (10.9%)
Depressed	18 (39.1%)	0 (0.0%)
Anxious	10 (21.7%)	0 (0.0%)
Having sex	9 (19.6%)	0 (0.0%)
Want birth control	15 (32.6%)	Not asked
Pregnant or wants pregnancy testing	12 (26.1%)	Not asked

On topics of substance use, mood, and sex approximately 20% to 50% of teens felt that clinicians would inform their parents.

Students also wrote that they would open up more if they were comfortable with their physician and if the physician revealed personal information. As a result, teenagers were asked about ways they could get to know their clinician. Most (43.5%) teenagers felt that more clinic visits with the same clinician would improve comfort level. Additionally, 32.6% reported that a community presence would help, 19.6% preferred that their physician be a sports team doctor, and 15.2% wanted their physician to speak to their class. The other options of being available in the school's nurse's office, talking at a school assembly, and seeing their physician on TV or in the newspaper carried no statistical significance.

DISCUSSION

This study found that outside of friends and family, teenagers identified medical professionals as the next most likely group with whom to discuss issues. This reinforces the work found by another study that highlighted the importance of physicians being a key influence for adolescents[9] and supports our claim to determine high yield anticipatory guidance. As determined by this study, if the adolescent does not request specific guidance, an appropriate topic to start with might be mood, stress, or vaccines. Our results also show that there are several barriers to teens discussing topics with their clinician, mainly patient understanding of confidentiality and familiarity of/comfort with the clinician.

With respect to confidentiality, adolescents understand that if self-harm or harm of others is involved, then confidentiality is broken, but substance use becomes a nebulous area. Many fear their parents will be informed of these behaviors and, due to the illegal nature of substance use, some fear law enforcement involvement. Topics of mental health and sexuality were associated with less fear

of being revealed to parents, although some students still had concerns. Explicitly stating the policy on confidentiality with both adolescents and their guardians can increase understanding for both parties, especially regarding police involvement. Two studies have found that discussion of confidentiality itself may be a rapport-building tool with teens and suggests starting early in adolescence.[10,11] Some examples of how one might reinforce confidentiality are provided by Rosen and Goldenring in their discussion of the use of the HEEADSSS mnemonic[12] and Bright Futures' written statement on their previsit adolescent questionnaire.

Lack of familiarity and comfort with the clinician were found to be barriers in adolescent care. Clinicians sharing information about themselves and initiating conversation on sensitive topics can improve comfort. Schaeuble and colleagues found that supporting adolescent independence and conveying genuine care promoted positive interactions with adolescents.[13] They recommended that the clinician in an office visit not conduct the interview with checklists/computer boxes.

On the topic of clinician familiarity, the majority of surveyed teens preferred interacting with their clinician in the clinic setting. Those who preferred outside clinic interaction favored the clinician participating in the local community or engaging with the adolescents at school. Clinicians interested in adolescent engagement outside of the clinic might opt for one of those avenues.

When looking at clinician gender preferences, data suggest that female adolescents disproportionately prefer a same gender clinician as opposed to male adolescents, to whom gender congruency matters significantly less. This is consistent with the findings of other studies that looked at physician gender preferences in adolescents.[14,15] Male clinicians should be aware that they might need to work harder than their female counterparts in achieving a level of comfort that will elicit honest responses with female adolescents. They especially may consider reinforcing confidentiality, revealing information about themselves, and conveying concern if they know they will be discussing sex, body image, stress, sexuality, or mood with female adolescents. Gender congruence did not impact discussion of substance use, but as mentioned previously, a reassurance of confidentiality would likely benefit the conversation.

This study was an exploratory study to see what topics adolescents wanted to discuss and how to best engage with them. Knowing this information, future studies may look at the sample scripts/questions provided by the authors of the HEEADDSSS interview or by Bright Futures and determine which questions would yield the most information or greatest effect on rapport building. One might also look at why vaccines were a topic adolescents wanted to discuss with their clinician. Is the impact an increase in confidence in their clinician, is it an expectation, or is there another function vaccine discussion serves? Future studies also may look at mood and stress preventive strategies and if the time spent with clinicians is enough for such strategies to create an impact.

Limitations

The population studied is fairly typical of much of Wisconsin, as Verona has a mix of rural and suburban students, but the sample size is quite low. Thus, surveying more schools and increasing the number of participants would provide a more accurate representation of adolescent viewpoints. The majority of students are white, similar to the demographics of Wisconsin, but having more diversity in race would allow for better generalizability. In addition, the surveyed population interests included science, technology, engineering, or medical field for their careers. Obtaining the student's personal history with well visits would help in determining if their replies were based on conjecture or experience. Finally, despite anonymity, a handful of teens did discuss how they answered the questions with a nearby classmate, which may have skewed some of the responses in a particular direction.

CONCLUSIONS

This study reinforces prior studies that looked at the importance of emphasizing confidentiality during visits, enhancing adolescent familiarity with the clinician, and acknowledging the impact of clinician-adolescent gender congruence on patient comfort in a Wisconsin school-based system. These findings supplement previous research by looking at specific topics adolescents wished to discuss with their clinician, and how confidentiality and clinician-adolescent congruence affected those topic discussions. Knowing that mood, stress, and vaccines are topics that adolescents may be more willing to discuss can help clinicians during the well visit, but more work needs to be done to look at the best intervention strategies and ways to initiate a positive discourse. This is important because adolescence is a time of great change. If clinicians can partner with patients at this stage of life, it may help create a healthier future.

Funding/Support: None declared.

Financial Disclosures: None declared.

REFERENCES

1. Hagan JF Jr, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. Third Edition. Elk Grove Village, IL: American Academy of Pediatrics; 2008.

2. Nordin JD, Solberg LI, Parker ED. Adolescent primary care visit patterns. *Ann Fam Med.* 2010;8(6):511-516.

3. Rand CM, Shone LP, Albertin C, Auinger P, Klein JD, Szilagyi PG. National health care visit patterns of adolescents: implications for delivery of new adolescent vaccines. *Arch Pediatr Adolesc Med.* 2007;161(3):252-259.

4. Irwin CE Jr, Adams SH, Park MJ, Newacheck PW. Preventive care for adolescents: few get visits and fewer get services. *Pediatrics*. 2009;123(4):e565–e572.

5. Mangione-Smith R, DeCristofaro AH, Setodji CM, et al. The quality of ambulatory care delivered to children in the United States. *N Engl J Med.* 2007;357(15):1515–1523.

6. Goldenring JM, Cohen E. Getting into adolescent heads. *Contemp Pediatr.* 1988;5(7):75-90.

7. U.S. Preventive Services Task Force. USPSTF A and B Recommendations. April 2016. http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/. Accessed November 15 2017.

8. Wisconsin Immunization Program. Percent of adolescents aged 13 through 18 years, by vaccine, region of residence and year. Wisconsin Division of Public Health. March 2017. https://www.dhs.wisconsin.gov/immunization/adolescentratesbyregion.pdf. Accessed November 22, 2017.

9. Klein JD, Matos Auerbach M. Improving adolescent health outcomes. *Minerva Pediatr.* 2002;54(1):25-39.

10. Klostermann BK, Slap GB, Nebrig DM, Tivorsak TL, Britto MT. Earning trust and losing it: adolescents' views on trusting physicians. *J Fam Pract.* 2005;54(8):679-687.

11. Rubin SE, McKee MD, Campos G, O'Sullivan LF. Delivery of confidential care to adolescent males. *J Am Board Fam Med.* 2010;23(6):728-735.

12. Rosen DS, Goldenring JM. Getting into adolescent heads: an essential update. *Contemp Pediatr.* 2004;21(1):64-74.

13. Schaeuble K, Haglund K, Vukovich M. Adolescents' preferences for primary care provider interactions. *J Spec Pediatr Nurs.* 2010;15(3):202-210.

14. Kapphahn CJ, Wilson KM, Klein JD. Adolescent girls' and boys' preferences for provider gender and confidentiality in their health care. *J Adolesc Health.* 1999;25(2):131-142.

15. Turow JA, Sterling RC. The role and impact of gender and age on children's preferences for pediatricians. *Ambul Pediatr.* 2004;4(4):340-343.

To earn CME credit for this journal article, visit https://www.wisconsinmedicalsociety.org/professional/wmj/journal-cme/ where you will be directed to complete an online quiz.

advancing the art & science of medicine in the midwest

WMJ

WMJ (ISSN 1098-1861) is published through a collaboration between The Medical College of Wisconsin and The University of Wisconsin School of Medicine and Public Health. The mission of *WMJ* is to provide an opportunity to publish original research, case reports, review articles, and essays about current medical and public health issues.

Visit www.wmjonline.org to learn more.