Parental perspectives on adolescent health-related confidentiality: Trust, responsibility, and disease etiology as key themes

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Purpose: As children progress through adolescence, they become more independent and more responsible regarding their health. This shift in responsibility from the parents to the adolescent poses a challenge for healthcare professionals who must consider both parties. Pediatricians and other healthcare professionals may encounter problems regarding consent and confidentiality. This study aimed to investigate the opinions of Belgian parents of adolescents concerning cases about confidentiality in adolescent health problems.

Methods: A qualitative methodology with semi-structured interviews and a case-based approach was chosen to answer our study aim. Belgian parents of adolescents were recruited voluntarily; 20 parents were interviewed. Parents' opinions on 4 different cases regarding confidentiality were obtained. Interviews were audio- and video-recorded and transcribed verbatim. Independent coding of the transcripts was conducted.

Results: Parents' opinions differ considerably when asked if a physician has to maintain confidentiality towards the adolescent, depending on the content of the case. Opinions appear underpinned by three factors: trust, responsibility of the different parties, and the etiology of the problem.

Discussion: This study shows that the nature, severity and frequency of the medical issue at hand shape the opinions of parents towards patient confidentiality, on top of the trust and responsibility factors also highlighted in previous work. This is in contrast to the Belgian legislation, which focuses on maturity regardless of context.

Key words: Confidentiality; Privacy; Qualitative research; Interview; Minors; Adolescent; Parent

Implications and contribution

This research suggests that three factors contribute to parental concerns regarding confidentiality for adolescents: trust between the different actors (adolescent, parent, physician), the responsibilities of these parties, and the etiology (the nature, severity, frequency) of the medical issue. This information may be used by physicians to build trust with parents, facilitating parents' caregiving role while also promoting confidentiality for adolescents.

Introduction

Healthcare-related confidentiality for adolescents is vital to provide high-quality care [1–3]. In order to ensure confidentiality between adolescent patients and health professionals, consultations without parents (or where the parents leave temporarily) are recommended by international guidelines [2,4–6]. Various studies demonstrate that adolescents highly value confidentiality, which in turn affects the likelihood that they will seek out medical care and confide in physicians [6–11]. A lack of (perceived) confidentiality constitutes a problem as "access to health care is significant during adolescence because it may modify risky behaviors, promote healthy habits, and improve health" [12]. Conversely, when confidentiality can be assured by health professionals, adolescents are more likely to disclose sensitive information and return for follow-up care [6,10,11]. Such confidential consultations are grounded in the ethical and legal principles of consent, competence, and confidentiality [13].

Despite the benefits of healthcare-related confidentiality for adolescents, physicians and other healthcare professionals regularly encounter parents who may feel entitled to information regarding their child's consultation, regardless of legal or ethical considerations [7,9,10,14,15]. Although studies on this topic are scarce, they indicate that parental opinions regarding confidentiality for adolescents in health settings are mixed [14,16–19]. Some parents recognize the potential benefits of confidentiality, but they also view confidentiality in adolescent health care as a potential impediment in their ability to be a 'good parent' and believe that not being involved in their children's health care would avoid their parental responsibilities [14,16,17]. One of the parents' main concerns is that they would not be able to adequately help their children because they may not be aware of important health issues [14]. Despite this prevalent ethical conundrum for health professionals, only a handful of studies have looked at the specific underpinnings of parental perceptions regarding

confidential health care among adolescents. The limited number of studies are either focusing on minority groups in the United States or on Australian children [14,16–18]. To our knowledge, evidence from a European context is non-existent.

This study aims to investigate the opinions of Belgian parents of adolescents regarding confidentiality in adolescent health care. Previous quantitative studies have shown that parents show conflicting views about confidentiality. Parents will identify positive features about it but simultaneously express concern about missing out on vital information [7,9–11]. Acquiring a deeper understanding about parental preferences concerning this topic can prevent or resolve issues in the workplace and even spark a policy-level discussion. Belgian legislation regarding this point is clear: an adolescent – regardless of their age – can exercise their patient rights autonomously (i.e., have confidential consultations) if the physician decides that they are competent to have a reasonable judgement of their interests (i.e., maturity principle) [19]. This approach leaves the decision to the physician who has to independently assess the ability of the adolescent to decide the (legal) degree of parental involvement.None the less, there is an undeniable need for a basic framework as pediatricians, general practitioners, and psychologists are often faced with situations in which their minor patients' confidentiality preferences clash with those of their parents/guardians [20].

Methods

A qualitative methodology was selected to complement the previous quantitative work to answer our research question. Participants were recruited on a voluntary basis through pediatricians in the researchers' personal networks based on their age, gender, being a parent, and educational attainment using snowball sampling. After confirming their interest to participate in the study, they were contacted within a week to arrange an online interview, since data collection took place during the COVID-19 pandemic. Inclusion criteria for this study were that participants needed to have at least one child between the ages of 12 and 17, could participate in an online interview, spoke Dutch, and were not a physician themselves. Participants received an email with the interview link. Informed consent was obtained from each participant prior to the interviews.

Interviews were conducted with 20 parents (10 mothers, 10 fathers) via Zoom. Participants were interviewed individually, not with a partner present. Participant demographics can be found in Table 1. Audio and video recordings were made of the interview [21]. The semi-structured interviews revolved around four cases. Each case was composed by a team of pediatricians and sociologists. They dealt with a specific topic in the medical treatment of a minor that could be a source of disagreement between parents and children. The topics of the four confidentiality cases were intoxication, sexually transmitted disease (STD), ultrasound and mental health issues. The cases were designed to cover a variety of different – but realistic – situations. After each case, we asked parents if they believed the physician should provide them with information regarding the treatment or consultation, even if the adolescent specifically asked them not to share it. See the supplemental materials for the specific wording of each case.

All interviews were conducted in Dutch by the same interviewer (E.D.). Field notes about observations, thoughts and ideas about the interview were made by the interviewer during and immediately following each interview. The interviews took place from March 2021 to August 2021. The average duration of the interviews was 51 minutes, with the shortest being 30 minutes and the longest being 80 minutes. Ethical approval of the Ethics Committee UZ KU Leuven was received prior to the start of the study (MP016910).

Independent coding of transcripts was conducted by two researchers (E.D. and C.D.). The first step of the coding process was open coding. Here, the data were summarized and concepts were constructed. These summaries were discussed in the research team, leading to developing a preliminary coding framework. The labeling process was done individually by the two researchers with meetings during the analysis to discuss divergences and agree on joint labels. In the second step, axial coding, general categories were created that applied to all interviews. The third step consisted of selective coding: associations that were made in the first or second step were confirmed by examining the categories and data that had been included and omitted across the interviews [22–24]. This coding process led to the formation of three main themes that were linked to confidentiality: trust, responsibility, and etiology[1].

[1] For an extensive overview of all relevant quotes by the study participants, see Table A1.

Table 1. Participant demographics

		N	%
Gender	Male	10	50
	Female	10	50
Age	Range	40-69 years	
	Mean	48 years	
Number of children	One	2	10
	Two	9	45
	Three	6	30
	Four	2	10
	Five	1	5
Civil status	Married	15	75
	Cohabiting	4	20
	Living apart together	1	5
Educational attainment	Secondary school	3	15
	Higher education (non-university)	9	45
	University	8	40

Results

Three key themes emerged from the analysis: (1) trust, (2) responsibility and (3) etiology of the health problem. These themes and subthemes (Figure 1) are described below:

Theme 1: Trust

Trust was a recurring theme that all parents addressed, regardless of whether they were 'for' or 'against' confidentiality. It could be divided into three subthemes: (a) trust between physician and adolescent, (b) trust between adolescent and parents, and (c) trust between parents and physician.

A) Trust between physician and adolescent

The most cited subtheme revolved around the confidential relationship between physician and adolescent patient. Parents believed it was important that the adolescent could seek and receive the appropriate care. If the child did not trust the physician or their trust was damaged, it might feel that they have nowhere to turn with their problem.

> "Then I would hate for that to stop her [to ask for help], because she knows the parents will be notified." – Parent U

> "It may also be important for the [child] to have a confidant separate from the parents."
> – Parent C

This trust relationship was mainly addressed in the cases regarding the STD and the mental health issue. On one hand, the parents did not want their child to forego the necessary health care in the absence of this trust. They felt that the child has a right to privacy and that they – as parents – did not need to know everything.

> "The risk [of asking the physician for information] is that [the child] won't go to that physician anymore, because their trust was violated there." – Parent N

B) Trust between adolescent and parents

The second trust-relationship was between the adolescent and the parent(s). Many parents felt that they have a strong relationship with their children and they believed their children would tell them what was going on. They felt that open communication was important in their family. This rationale surfaced among parents in favor and against confidentiality. Typically, parents perceived trust between them and their children as why the physician did not need to provide any information.

> "We are a warm-hearted family, with open communication. Here, we tell each other [about it]."
> – Parent L

> "For me, the physician does not need to call me, I will find out from my own son or daughter what happened." – Parent B

> "I would prefer to hear it all in detail, but if my daughter indicates that she would rather solve it in confidence with the physician, then I do not think that they [the physician] should say it." – Parent M

C) Trust between physician and parents

The third trust relationship was between the parent and the physician. This relationship was the least discussed but cited by at least one parent in every case. More specifically, parents talked about the relationship between themselves and their family physician. Several parents expected that the family physician would be more likely to tell them about the adolescent's health problem rather than a specialist or an (unknown) family physician.

> "I would expect that our own family physician will be more likely to provide me with information [in comparison with a specialist], because of that established relationship of trust." – Parent K

> "Obviously, I would trust the information from the family physician a little bit more than from a physician that I don't know at all." – Parent D

Theme 2: Responsibility

Responsibility is the next theme that was identified. This theme included the responsibilities of the (a) physician, (b) parents, and (c) adolescent. The attributed importance to these different responsibilities created conflicting views.

A) Responsibility of the parents

The concept of 'parental responsibility' was mainly used by parents who preferred to be informed (and thus, are 'against' confidentiality). Parents argued that they were responsible for their children's well-being and should therefore be informed.

> "I think that under the age of 18, it is still your job as a parent to guide them and, if something goes wrong, to make them aware of their actions and how to solve their problems." – Parent R

> "We have full responsibility over our children, on every level. So yes, I would want that to be reported to me." – Parent K

However, some parents who favored confidentiality also cited arguments of parental responsibility. They felt it was their own responsibility to find out what was wrong with their child, not the physician's responsibility to tell them.

> "It's my responsibility to find out what my child does. It is not the physician who needs to tell me." – Parent Z

Finally, the financial aspect of health care was also considered a parental responsibility. Some parents wanted to know the reason for an examination, if they were expected to pay for it.

> "If you receive the bill, you should also know why that examination occurred."
> – Parent N

> "So if he wants us to pay for it, we can ask for more information." – Parent T

B) Responsibility of the physician

The responsibility of the physician was largely talked about by parents who were pro-confidentiality. When the physician decides not to tell the parents, they were held responsible for the treatment choice, follow-up, prevention and proper referral of the adolescent. The physician must also raise the alarm in time and inform the parents if necessary.

> "But if the physician chooses not to communicate this to the parents, I think that he needs to take over a part of the parental role from the parents. I perhaps expect too much. But I expect that he takes care of the problem, that he pays attention to prevention and that he also gives her […] at least some advice." – Parent A

> "Hopefully, we can assume, especially at that young age, that the GP will sound the alarm if something needs to be discussed." – Parent H

C) Responsibility of the adolescent

Adolescence is a time to experiment. It is a 'responsibility' of adolescents to make mistakes and learn from them. This reasoning was brought up by several parents.

> "I think everyone has the right to commit one or a few mistakes. If you give your child a number of norms and values and they cross the line, they might learn a lot from it." – Parent O

> "The youth should be allowed to experiment and test their limits" – Parent H

Most parents accompany their child to their physician's consultation and have a difficulty imagining their child going to the physician alone. Yet some parents praised the child for the responsibility they took by going to the physician alone. They believed this independence is a sign of the maturity of the adolescent.

> "I think he should be appreciated for his independence of going to the physician alone."
> – Parent I

Theme 3: Etiology

The (a) medical nature of the case , (b) assessment of the severity of the problem , and (c) how often it has already occurred played a role in parents' perceptions.

A) Nature

Parents made a distinction between physical and mental health problems. A mental health problem was regarded as a sensitive issue that needed to be handled with more care in terms of confidentiality.

> "I do think that a child who does not feel comfortable in their own skin [psychological problem], is much more important than a physical problem that can be solved medically." – Parent N

> "This is indeed a psychological problem, which makes this case a little more difficult. A mental health problem is always more difficult." – Parent D

> "It depends on the child, on the situation, on the relationship of trust, on the nature of the contamination or infection." – Parent V

Some parents used the sensitivity of this subject as an argument that absolute confidentiality was necessary. This was in contrast with other parents who felt that they absolutely need to be informed, specifically because it is such a sensitive issue.

> "What's wrong with being drunk once? It's not a big deal so we don't need to keep that confidential. The previous issue, the STD, touches more on the intimacy of that child. In that case I understand the need of confidentiality better." – Parent A

> "I would like to know everything, so that I can help my child. If you only hear half a story you might not be able to help or support them entirely." – Parent L

B) Severity

The severity of the problem was also discussed. For example, parents believed the ultrasound is a medical examination designed to detect a potentially serious health problem. Thus, many wanted to know why it occurred.

> "I think the doctor should report or say why the ultrasound took place. I would be anxious that it might be in response to a potentially serious illness or incurable disease." – Parent C

> "Of course, it also depends on the severity." – Parent X

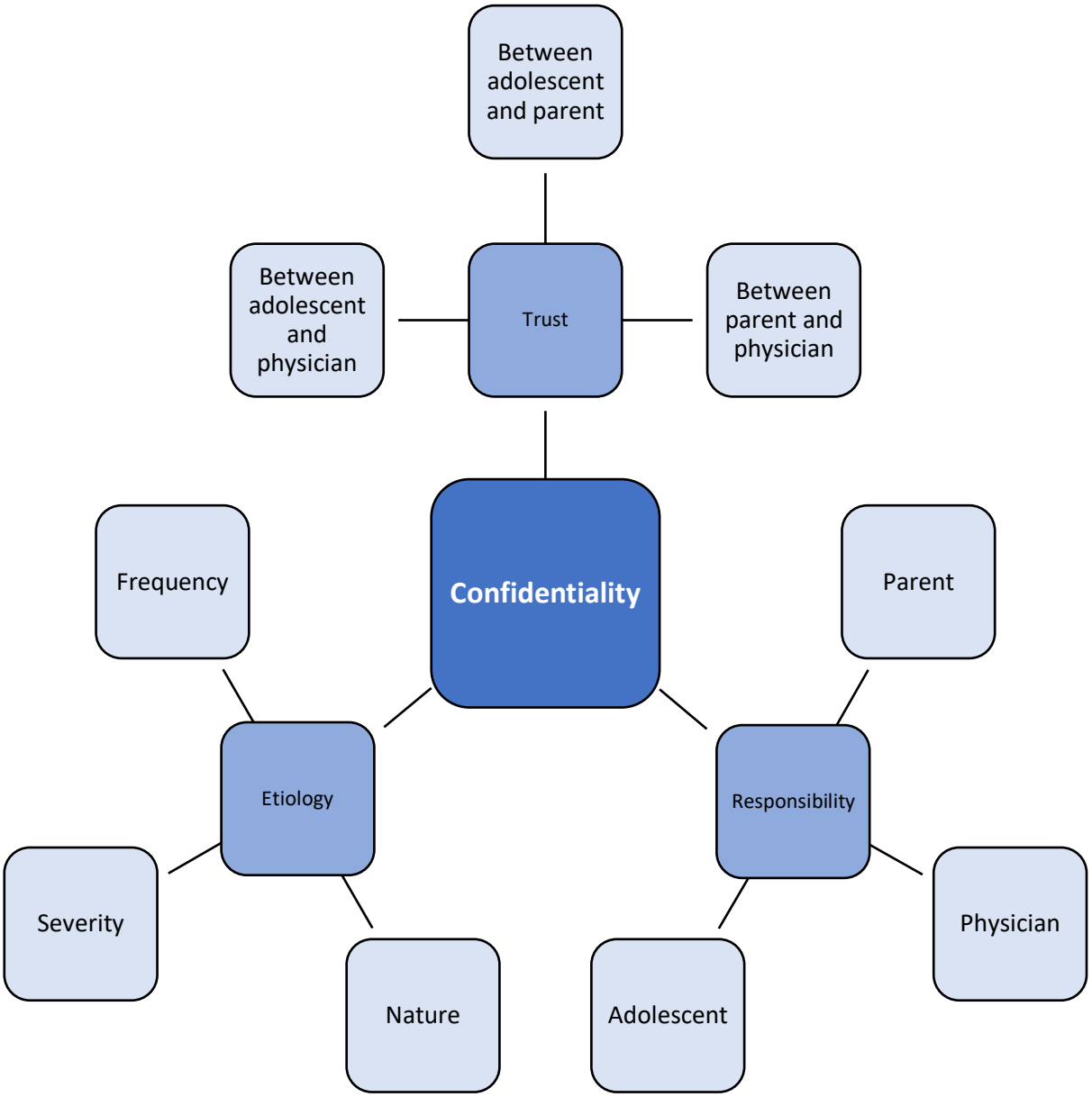
C) Frequency

Parents felt that the physician should take into account how often the health care problem has already occurred when deciding whether to inform the parents. This arose mainly when discussing the case of intoxication.

> "If that happens systematically or gets completely out of hand, then it's important to inform the parents." – Parent Z

> "If that happens once and they ask not to report it, okay. [If] this is the second or the third incident, then the physician should inform the parents." – Parent O

Figure 1. Conceptual map of the main themes that influence parental perceptions regarding adolescent confidentiality



Discussion

In this study, parental opinions regarding health-related confidentiality for adolescents were studied through semi-structured interviews. We contribute new insights to the limited literature on this topic. Generally, parents' opinions regarding confidentiality for adolescents are mixed. Three main factors contribute to parental concerns regarding confidentiality for adolescents: the degree of trust between the different actors in this context (adolescent, parent, physician), the responsibilities of these parties, and the etiology (the nature, severity, and frequency of the medical issue). The first two factors closely mirror those found in previous qualitative studies in the United States and Australia [14,16,17], but our case-based approach also allows us to contribute a highly relevant third factor that has previously not been explored in qualitative (or quantitative) research on this topic.

Trust is considered to be a key influence in previous studies on this topic [16,17]. Three trust relationships are highlighted by parents in our study: physician-adolescent, physician-parent, and parent-adolescent. Previous research shows that adolescents benefit from the physician's assurance of confidentiality since they are more likely to seek care and disclose sensitive information [1,6,9–11,25,26]. Parents recognize this benefit of confidentiality: they do not want their child to avoid seeking care when they present health problems. But if parents are unaware of their adolescent's health problems, they may incorrectly assume that all is well [9]. Trust between physician and adolescent was prominently discussed in cases regarding STDs and mental health. Parents consider it important, especially in these areas, to value confidentiality between the physician and adolescent. The physician-parent relationship can suffer when a parent discovers that they were not informed of certain information, when they feel that the physician should have informed them. These conflicting opinions can potentially damage the physician-parent-relationship [18]. It is essential that physicians maintain a good relationship with parents: our data indicates that parents with much trust in their physician are more likely to trust the information that physicians convey – but, interestingly, also expect these physicians to share this information with parents rather than uphold the adolescent's confidentiality [14]. The latter is particularly true for the family physician because trust in them is usually high, while specialists or other professionals are considered less likely to break confidentiality. Building trust with parents so that they feel safe entrusting their children's care is "not a simple or swift task, but it is nonetheless essential if

both health professionals and parents are to achieve their shared goal of promoting the safety and well-being of young people" [9]. Many parents feel that they have a strong relationship with their children. They value open communication and expect their child to bring up health problems themselves. Parents mention this as a reason for why the physician does not need to provide information. Research shows that "although teens are more likely to disclose sensitive health topics if they are given assurance of confidentiality, these assurances do not seem to impact the teens' discussion of these issues with their parents" [6].

Parents also consider themselves responsible for their child's well-being [27]. They feel a need to be informed of their child's health in order to fulfill their parental duties and be a 'good parent'. This feeling of responsibility is expressed by many parents in this study. Some feel that they maintain this responsibility until their child is a legal adult, others feel less responsible as their child grows older. Parents in this study mainly attached importance to their responsibility as a parent in the case about intoxication. They found it necessary to be informed about their child's alcohol (mis)use, and thus fulfill their duties as parents. Responsibilities that parents impose on themselves are also reflected in previous research [14,16,17]. In their study among Australian parents, Sasse et al. framed this responsibility as various 'roles' that parents associate with parenthood: caretaker of the child, expert, and legal guardian [14]. However, children are also expected to take responsibility for their health (care) as they grow older [1,2]. Therefore, some parents also believe that adolescence is a time for experimentation and that adolescents should be allowed to make mistakes (e.g., intoxication) and learn, without them knowing about it. Other parents who feel that they should not be informed, place greater responsibility with the physician. When a physician decides not to inform the parents, they are now responsible for communicating with the adolescent about their (risky) behavior. The other responsibilities that parents attribute to a physician who assures confidentiality to the adolescent are twofold. Physicians need to provide good treatment and follow-up, and organize proper referral to experts (and parents) when health problems become more severe.

A final theme that was frequently discussed – but unexplored in previous research on the topic – is the etiology of the health problem. This comprises the nature, severity and frequency of the problem. Parents feel that the mental health and STD-cases refer to sensitive

subjects that need to be handled with greater confidentiality. Opinions of parents on how to tackle the issue of confidentiality regarding these subjects are divided. Some use the sensitivity of this subject as an argument that absolute confidentiality is necessary so that adolescents can discuss their problems in confidence. Others cite this as the main reason to be informed as they feel it is necessary to support their child with such a delicate issue. Parents did not only make assumptions about the severity of the drunkenness but also about other cases. Regarding the ultrasound case, most parents cited fears of a serious underlying health problem as why they want to be informed about this. The STD-case was viewed not only as more intimate but also more severe problem than the intoxication. These severity judgments are, of course, subjective and vary between parents as there was no information about this in the case description. The frequency of the health problem is also important to many parents in their confidentiality preferences. This is mostly the case for alcohol intoxication. If this is a one-time-event, the physician should forego informing parents. However, when alcohol misuse becomes a repeated phenomenon it can lead to serious (long-term) health problems and parents want to be informed. Even though this study did not exhaustively explore all possible etiologies and the related parental opinions, it shows the relevance of disease and context in this matter. Future research could provide further information on these findings by interviewing adolescent and parent dyads.

This study also has some limitations. Most notable are the sample size and frame; that is, a relatively small number of Belgian parents, limiting the study's generalizability. Additionally, the majority of parents interviewed were highly educated. Although it is not unusual to have a majority of highly educated participants in these types of studies, the views of lower educated individuals would also have been valuable. Finally, selection bias may be introduced because the parents who consented to be interviewed may hold different views from those who declined. Future studies should be mindful of these shortcomings that also provide avenues for additional research. For example, gender and status differences in perceptions received little attention in the current study but may be important to investigate further to confirm if the parental views expressed here reflect those of parents more generally.

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Case 1

Your son went to a party with friends and drank alcohol. Afterwards, he tripped and fell on the floor and unfortunately ended up with his hand in a glass shard. Because of this injury, he was taken to the emergency room where a doctor stitched the wound. Your son realizes that he will be in trouble when you (as a parent) will hear about the intoxication and asks the attending physician not to inform you about it.

Which decision do you believe the physician should make?

□ The physician reports the intoxication to the parents.

□ The physician does not report the intoxication to the parents.

Case 2

Your daughter has recently started a romantic relationship and has an annoying problem for which she goes to the general practitioner. They diagnose a sexually transmitted disease (STD), which is easy to treat without side effects. She asks the practitioner not to say anything to you (the parents) about this infection.

Which decision do you believe the physician should make?

□ The physician reports the infection to the parents.

□ The physician does not report the infection to the parents.

Case 3

You received a hospital bill in the mail this week for an abdominal ultrasound performed on your son. You ask about the reason for this, but your son will not say. You contact the general practitioner who made the request for this examination and ask for the reason for this examination.

Which decision do you believe the physician should make?

□ The physician reports the reason for the examination to the parents.

□ The physician does not report the reason for the examination to the parents.

Case 4

In recent weeks you have noticed that there is a problem with your daughter: she sleeps poorly, always retreats to her room, doesn't talk to her friends anymore, is often in a gloomy mood and eats badly. You know that your daughter went to the general practitioner for this a few days ago, but you do not know what was discussed there.

Which decision do you believe the physician should make?

□ The physician reports the findings to the parents.

□ The physician does not report the findings to the parents.

Table A1. Overview of key quotes by study participants per theme

Parent	Trust	Responsibility	Etiology
Parent O	- Actually, my reasoning is that the child must be able to trust someone and have the right to do something stupid for a change. (Case 1) - But in general, I think it is important to put your child's trust and additionally his health first. - It's not your trust, it's your child who trusts someone so actually in whom you trust doesn't matter much.		- If that happens once and they ask not to report it, then the doctor should not tell me. If your case now says it is the 2nd incident or the 3rd incident, in that case, he should tell me. (Case 1)
Parent R	- A general practitioner perhaps goes a step further. He is really a confidant. We also have a very good relationship with our GP. (Case 1) - I would like to know a lot more, but then as a parent you have to withdraw and just be glad that there is someone who your child accepts as a	- I think that under the age of 18, it is still your job as a parent to guide them and, if something goes wrong, to make them aware of their actions and how to solve their problems. (Case 2)	

	confidant. (Case 4) - if they really don't want to talk about it with their parent, I would just demand that there is help somewhere and no matter how difficult, I don't think the doctor should tell me. I think the trust between the doctor and the child is important, more important than my own worries. (Case 4) - I prefer that there is a relationship of trust even if it is with someone external and not with me as a parent. (Case 4)		
Parent H	- I think sometimes a GP does not feel so safe for them. (Case 2)	- Then I must have a lot of confidence that the GP will handle the problem in its entirety. (Case 2) - You can't just cut out the parent. (Case 3) - At such a young age, you should be able to count on your GP to sound the alarm if something needs to be discussed. (Case 4)	- When it comes to alcohol, one should know that he has had one too many. (Case 1)

		- The youth must be able to experiment and test their limits. (Case 1)	
Parent I		- I think he should be appreciated for his independence in going to the doctor alone. (Case 1) - I hope that the doctor will be responsible for following her in taking the medication. (Case 2) - A 15-year-old is in his experimental phase in life and has a sense of not needing to know everything as a parent. (Case 1)	- But I do think that the parent should have the right to be able to ask the question, is it serious or not? (Case 4)
Parent K	- I would expect of my own GP that he would tell me this because of the relationship of trust there is between us. (Case 1)	- It is hard to imagine that one of my children at the age of 15, would go to a doctor alone. (Case 4)	
Parent L	- I hope I would have a good relationship with my daughter so that I would know it before she went to the doctor. (Case 2) - We are a "warm" family, with open communication, where everything is told. (Case 3)		
Parent M	- I would prefer to hear it all in	- In the end, you want to protect them and	

	detail, but if my daughter indicates that she would rather solve it in confidence with the doctor, then I do not think that the doctor should say it. (Case 4)	know what is happening. (Case 4)	
Parent A		- The child went to the doctor for a problem and he solved it himself, so I think what I don't know won't hurt me. (Case 2) - But if a doctor chooses not to communicate this to the parents, I do think that he has to take over the parental role from the parents and that he has a strong advice to give to the child. (Case 2) - I may be expecting too much, but I expect that the doctor will solve it, that he will do prevention and that he will give her a piece of his mind about ethics or at least some advice on that. (Case 2) - as a parent you are responsible for the psychological/physical well-being of your child. (Case 3) - I think you have that responsibility again here. That is not only a	- If it happens a second or third time, then as a parent I would want to know. Because then it really becomes more of an educational role that a doctor cannot take in our place. (Case 2) - There is no shame in being drunk once, but if it happens every week, then as a parent you want to know. (Case 1) - The previous issue, the STD, touches more on the intimacy of that child. So there I understand the confidentiality better. - What is wrong with being drunk once? It is not a bad

		right but also a duty as a parent. (Case 4) - Again, until a child reaches the age of majority, legally speaking, the parents have the responsibility over that child. If the doctor does not want to tell the parents, then the doctor does have a responsibility to protect the child.	thing, so we do not need to keep it confidential. (Case 1) - I do think that the doctor should outline the problem: physical, mental, worrying, normal for the age, not worrying. (Case 4)
Parent N	- The risk is that they will not go to that doctor anymore because their trust is being betrayed there. (Case 2)	- I think that as a parent you really have to point out the consequences to your children, up to the age of 16. (Case 1) - If you get the bill, you should know why that examination took place. (Case 3)	- A child that does not feel good in its own skin is, in my opinion, much more important than a problem that can be solved medically. (Case 4)
Parent S	- You must be able to give that child privacy. (Case 3)		
Parent T		- This independence may also include paying for his own research. (Case 3) - So if he wants us to pay for it, we can ask for more information. (Case 3)	
Parent Z		- It is my own responsibility to find out what that does to my child. It is not for the doctor to tell me. (Case 1)	- But if this happens systematically or really gets completely out of hand, it is important to

		- I would rather that my children experience this once and then learn from it. (Case 1) - The younger they are, the more the care still lies with the parents and I also assume that the doctor will consider this. (Case 3)	inform the parents. (Case 1)
Parent U	- Then I would think it a shame if it stopped her from going to the doctor if she knows that the parents will be informed. (Case 4)		
Parent V		- If you pay for an investigation, you want to know why it took place. (Case 3) - I think that as a parent you have the right to know how your child is doing. (Case 4)	- It depends on the child, on the situation, on the relationship of trust, on the nature of the contamination or infection. (Case 2) - You don't just do an ultrasound for fun. (Case 3)
Parent D	- I would naturally trust the explanation given by the family doctor a little more than a doctor I do not know at all. (Case 4)	- Of course, it is up to the doctor to decide whether to share it or not. And I suppose that the doctor has the patient's best interests at heart. (Case 4)	- This one is perhaps a bit more difficult because it is indeed psychological, which is always more difficult. (Case 4)
Parent C	- You have to have faith in the doctor, in his or her assessment		- Personally, I think 12-13 years is too young to have

	of whether or not he should tell the parents. (Case 2) - It is perhaps also important for the daughter or son to have a confidant separate from the parents. (Case 4)		sexual relations. I think 15 is also very young, but they say that it starts earlier. (Case 2) - I think the doctor should report it and say why the examination took place. I say that because I would be afraid that it might be because of a serious illness, an incurable illness. (Case 3)
Parent W			- This is not just a flu what they have then. (Case 2)
Parent B	- I don't need the doctor to call me, I will find out from my own son or daughter what happened. (Case 1)		
Parent X	- When you live together as a family I don't think there should be many secrets. (Case 2) - It is to see how your control over your son or daughter is. If you can trust her or him and then something like this happens, I		- Of course, it also depends on the severity. (Case 1)

	could accept it. (Case 1)		
Parent P	- I think honesty should play a big part in that. (Case 1)		

Note: Case 1: Alcohol; Case 2: STD; Case 3: Ultrasound; Case 4: Mental health. Quotes without a case specified indicate general remarks by participants.