Possible Pitfalls in Adolescent Medicine in Flanders: A Qualitative Approach

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Keywords

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Abstract

Objective:

Adolescent healthcare consists of a triadic relationship involving the physician, adolescent patient, and parents. In Belgium an adolescent patient can have a high degree of autonomy based on a maturity assessment by the physician. This qualitative study assesses the perspectives of general practitioners and families with adolescent children on the rights of adolescent patients.

Methods:

The research methodology employed focus group discussions with ten general practitioners and semi-structured interviews with twelve families recruited via social media. Physicians practiced in Flanders, and families included adolescents aged 14 to 17 years and their parents without a medical background. Interviews were conducted online, with data analysis guided by the Qualitative Analysis Guide of Leuven (QUAGOL).

Results:

The analysis revealed some of the specific challenges in daily clinical practice. The identified pitfalls include an insufficient awareness of the details of patient rights among both physicians and families, the passive role of adolescents, the effect of parenting styles and the loss of intricate knowledge of the family context in group medical practices.

Conclusion:

These challenges underscore the complexity of this triadic relationship. A deliberate and mindful approach, characterized by effective communication and active engagement of all stakeholders is needed to guarantee high quality adolescent healthcare provision.

Introduction

In the contemporary medical landscape, characterized by a departure from the paternalistic model, the significance of effective communication and establishment of a sound physician-patient relationship in delivering high-quality healthcare has garnered increasing attention (1). When dealing with adolescent patients, a multifaceted three-party relationship emerges (patient-physician-parents) that inherently embodies complexities (2). Within this triadic system, the central figure is the adolescent patient, whose cognitive faculties and decision-making skills are in a state of ongoing development and evolution. Notably, teenagers exhibit a greater propensity to make imprudent decisions in 'hot' circumstances characterized by heightened emotions, peer influence, and engagement of social cognition (3). This poses a challenge to physicians who must find an equilibrium between the needs and capacities of the adolescent and the role of the parents (4). Safeguarding the rights of all individuals and ensuring the exercise of autonomy within the boundaries of cognitive and competence levels are central tenets of medical ethics and pertain to adolescent patients (2, 5).

In Belgium, Article 12 §2 of Chapter 4 of the Patients' Rights Act tasks the physician with evaluating whether the adolescent possesses sufficient "maturity" to act autonomously (6). This level of maturity determines the level of parental involvement and the consideration of adolescent opinion (7). When an adolescent is deemed sufficiently mature, he or she can exercise the patient rights autonomously and -if they request it- exclude any parental involvement. This assertion of autonomy primarily pertains to two crucial patient rights: consent and confidentiality. Confidentiality concerns the professional secrecy and trust within the healthcare relationship. Consent, within the realm of patient law, encompasses the patient's right to participate and make self-determined choices (8).

In contrast to Belgium other countries have chosen for an age-based approach. In the Netherlands, full autonomous decision-making is granted to minors at the age of 16, in Italy only at the age of 18 (9). This seems more standardized but is less adaptable

to individual growth trajectories and prevents adolescents to seek individual medical care at younger ages (10). The Belgian system is person- and context-dependent and relies on the physician's judgment. Nonetheless, every adolescent, every physician and every relationship is unique. And the legal context does not provide concrete guidelines to the physician to make this assessment (11). The decision to grant medical autonomy to an adolescent is influenced by the specific medical problem, the maturity of the adolescent, the willingness of the parent(s) to cede control and the leadership role of the physician (1).

The central question that arises during clinical practise is this: what are the barriers and facilitators to good adolescent healthcare in general practice in Belgium? In this study we explore this question using a qualitative research methodology.

Methods

Data were obtained through structured interviews with general practitioners and families. The primary focus was to identify successful practices as well as obstacles within general medical settings, along with the reasons behind such challenges. Furthermore, the interviews aimed to delve into how these obstacles were addressed and what changes should be considered.

General practitioners were recruited via email and various social channels, primarily through the collaborative network of UZ Leuven and the Academic centre for Primary Care (ACHG) inviting Dutch-speaking physicians practicing in Flanders. Exclusion criteria were not present in the study. Families were approached through Facebook via an open invitation to participate in a voluntary study. The invitation stated that we intended to recruit parents of children between the ages of 14 and 17, while the parents could not be employed in the medical field.

Participants received study information and provided informed consent. At the start they were informed of their option to withdraw from the study at any time. The interviews were conducted via Microsoft Teams and lasted approximately one hour for general practitioners, with an average duration of 35 minutes for families.

Interviews with general practitioners followed an interview template, designed on a literature review and refined through exploratory talks with three general practitioners covering a range of different concepts. Subsequently, seven general practitioners participated in three focus groups, with one individual interview due to scheduling limitations. Focus groups encouraged dynamic discussions, diverse perspectives, and deeper insights through interaction. The process followed the "Start-Stop-Continue-Adjust" principle, integrating feedback from previous discussions to refine and enhance the interviews. Based on these findings, a semi-structured interview protocol was developed and validated for the participating families. Twelve families were included in the interviews, comprising ten parents and twelve adolescents. Each adolescent was interviewed together with a parent. The questions encompassed a range of topics, with some specifically directed at either the parent or the adolescent and several case scenarios. As a concluding query, participants were asked to reflect on their experiences with current practices at the general practitioner's office and whether the interview process might influence their future interactions with medical personnel. After ten interviews data saturation seemed to be achieved as the two subsequent interviews failed to reveal any new elements. This indicated that the sample size was sufficient to capture the full range of perspectives pertinent to the study.

Each interview was audio-recorded and later transcribed anonymously. Participant names were replaced with randomly assigned numbers based on their interview role (e.g., parent, child, general practitioner). The Qualitative Analysis Guide of Leuven was employed as the analytical framework (12). The iterative coding process ensured that initial codes were generated from recurring concepts and patterns. Conceptual narratives were then developed to encapsulate the emerging themes and to interpret the underlying meanings within the participants' accounts. The coding framework was discussed and validated in successive reflective

FIGURE 1: Schematic overview of the triad, the actors, and the interactions.

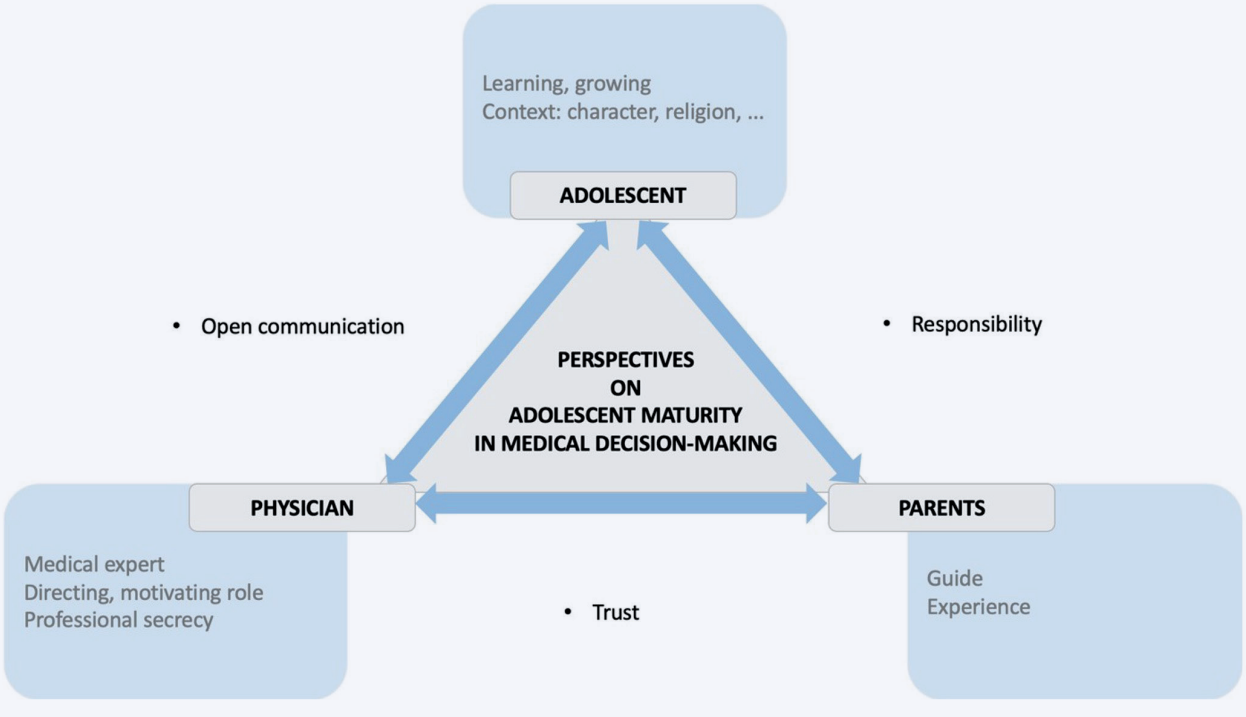

TABLE 1: Selection of quotes capturing the essence of various opinions.

RESULT, SECTION 1	Parent 2: I find that she approaches life very sensibly, wisely, and pragmatically. Since she was small, I have always let her answer questions like: what's your name, how old are you...? But when they ask about insurance, she also looks at me, and I can say, 'that's for us, X.' Those are the things I respond to.
	GP 1: When it comes to motivation, there can be two sides to it: sometimes it's actually good that parents are present when they are pulling in the same direction as a doctor (uh), and then it's sometimes good that they are there to convince the young people.
	GP 3: The logical versus the affective... And the art is then to turn it into a positive story, like "I am going to help you."... We are emotional beings. It is a very valid point that logic is usually 'not the way to go.'
	GP 4: Or I call and say, I'll schedule an appointment for them at the hospital or with a psychologist to make sure they go there and that it's not postponed indefinitely... And next time, I try to ask: "Have you called? Were you able to make that appointment?"
CHALLENGE 1	Child 5: Yes, I do find that important. Because I didn't know that at all, and it's crucial to know that not everything is automatically shared with my parents when you ask.
	Parent 10: I do think it's important, "child 12", that if that happens, I would feel comfortable if you asked us to step outside because you want to say something personal to the doctor, and you can express yourself at that moment. We don't necessarily have to be there. The most important thing is that you get help at that moment.
	GP 1: I think it's crucial that the young person trusts their general practitioner and knows that what I come here to discuss remains confidential: If I want it not to reach my parents' ears, then it stays confidential, because otherwise, you'll never see them at your door again.
	GP 1: I think the advice from the medical board is that young people from the age of 14 can assess whether parents should be informed or not. If you don't respect that, well, then the therapeutic relationship with your patient has exploded from the start.
	GP 8: No. You have to point it out in advance. Because they assume that it's an open book where everything is discussed during coffee.
CHALLENGE 2	Child 8: Yes, I find that important. That a doctor involves me in the conversation. And doesn't talk over my head with my parents. The doctor should address you directly, so you don't feel unnecessary.
	Child 8: I don't think many peers worry about this. They just go with the flow and ask the doctor if they don't want something to be said.
	GP 2: Young patients with a chronic condition are generally a bit more mature than those who haven't experienced much.
	Parent 1: They also visit the doctor so infrequently; they are simply not aware of it yet. I do think we need to educate them better about it. When I see their peers, especially those with mental health issues, they need much more guidance and autonomy. But here, it's just a common cold or an injury.
	Child 11: I would be more afraid to ask to speak to the doctor alone.
	Parent 7: I do find that important. Because I mean, in a few years, in three years, he'll be of age, then he has to do it on his own. So, he should already practice and do it now, under guidance. I think it's important to instill that in your upbringing. That a treatment needs to be followed up, and you shouldn't wait too long to go to the doctor and so on.
	GP 10: Naming that we do hear them and that they really do have something to say. I think we already do that, but do we always do it equally well and consciously? That's what these things are always good for, to reflect more on such matters.
	Child 12: Doctor Tom, for example, always talks to mom, and then she [mom] looks at me and says: what do you think? ... and then mom says: it's for you, so be sure to listen.
	Parent 1: What was crucial for "child 1": the doctor who treated him became a real role model for him. He plays hockey himself, has had knee problems himself. And then they talked about hockey, about knees, about selection...
	Parent 7: Would it make a difference for you if the doctor indicates that he also wants your opinion? Child 9: Yes, because if he doesn't say that, then I wouldn't think of doing it myself.
	GP 8: You could also work proactively, for example, by already displaying in your waiting room or on your website that it's perfectly possible for young adults to come for consultation alone.
	GP 10: Actually, it's important to make children aware of medical confidentiality as well. I say that in the context of when there is already a problem. But maybe we should tell them at a time when there is no problem yet.
	Parent 10: I think a patient should know that they can always turn to a doctor. That you can trust them. That young people know that. That could be a topic of discussion in education. If they are already getting a life perspective, throw that in there too... So it's crucial that this sentence is spoken. Especially for people who are less outspoken. And for young people who already have 2 glass ceilings to break through. I think it would help if that is consciously included at the beginning of a conversation.

CHALLENGE 3	Parent 7: I'll send "child 9" to the doctor alone sometime... Yes, when they are small, you automatically make decisions for them. But as they grow older, begin to understand their bodies better, you have the pitfalls of taking over because you're used to it, and the doctor tells you what to do. But making it explicit would be better for all parties.
	Parent 5: I think the doctor is better positioned to guide that. The parent won't have the reflex to go sit in the waiting room themselves.
	GP 8: But you can't make a patient or a parent run faster than they can. What I mean is: if those parents are convinced that the weight loss is due to exercising, then the question is: are they deluding themselves, or are they not aware that they are deluding themselves?
	GP 4: In cases of eating disorders, those are difficult consultations because the girl doesn't want to see the problem, and the mother wants us to solve it every time... Often, it's also a conflict with the mother, right. You can hardly say that when she is sitting there.
	GP 8: Yes, every family also has its own dynamics. And you have to try to read that dynamic a bit... And actually, to see past that somewhat dominating relationship between parent and child. But certainly, also to question it. To find out from those parents what the perspectives of mom and dad are. And what has happened in the past... We should certainly not limit ourselves as general practitioners only to somatic complaints and somatic treatments.
	Parent 8: And I was there just for show. Actually, I was happy about that; as he himself was the one who was worried.
	GP 9: On the other hand, I think in follow-up, especially for mental health issues, it's also important, if the child trusts or wants it, to try to involve the parents as well. If they don't want that, it's difficult to do. But otherwise, there is also a tendency to lose track of your patient somewhere.
	Child 10: From school, you have to call your parents, and then our mom would certainly say, "I'll come over, and then we'll go to the doctor together." Because I find that not yet suitable for me to do alone. Not that I can't do it, but I don't feel so great about doing it alone yet. It's still nice to have someone with you who is informed.
	Child 6: I'd prefer it in the waiting room. But it would be better if the doctor suggests it themselves... I would like the general practitioner to do that for me if he realizes that I want to discuss something separately. Because I don't think everyone dares to say that, especially when the parent is present.
	Parent 1: That seems nice to me, for both me and the children and the doctor because you can establish a connection at that moment and delve deeper. I think it can be nice for the child to speak freely but still be comfortable knowing that it will be discussed with us afterward. That the child doesn't have to bear the responsibility of decisions yet.
	GP 3: ...the dominant role of the doctor is important and expected...
CHALLENGE 4	GP 8: Perceptions and patterns of illness can be hereditary, but they are also transferable in a social context. For example, a child born to non-working parents is very likely not to work. Similarly, if parents consult for the slightest ailment, their children, when they have children of their own, are likely to consult for minor ailments as well. This is a form of health education. ...What I also regret in the entire field of general practice is the reduction of home visits. I know that home visits are very time- consuming. But a home visit is something very special. You actually enter somewhere as an outsider. You come in through the back, through the kitchen to the living room. That creates an image of the general course of affairs within that family.
	Parent 10: Usually, I call the general practitioner afterward. If I have any questions, I can just call I think that's also because the general practitioner knows us well and knows how things work here.
	GP 4: Not just alone, but I have little say in that. Patients book appointments online.
	GP 8: I have a younger colleague, and I have the habit of framing most patients, placing them in a larger context. And I always try to say: just because I say it, doesn't mean it's true. You should always rely on your own intuition.
	GP 5: In our group practice, we have determined that 16-year-olds may potentially come in alone, and all colleagues follow this practice. If younger children come, we still see them, but we say, next time your parents should definitely be present.
	GP 9: Yes, I think it's indeed difficult to assess that, so that's why I would quickly try to save some time or maybe discuss it with my supervisor, to see if they know something about that background.

meetings, ensuring inter-coder consistency and interpretative rigor. The final narrative underwent evaluation by a methodological expert before being used to draft the final written text.

Results

In our study, 10 physicians, 10 parents, and 12 adolescents participated from February to August 2023. Notably, 92% of the parents taking part were mothers. Among families and general practitioners, one-third lived in urban areas and half worked in city practices, respectively. Additionally, 70% of doctors worked in group practices, and 33% of children had a medical history, with 2 experiencing frequent illness. All participants were representative of the mainstream population of Flanders. All participants were native to the country, with no reported migration backgrounds, and they identified with the predominant cultural and religious norms typical of the national context.

The analysis of the interviews shows that the current healthcare system generally operates efficiently. Trust, responsibility, and

open communication are fundamental pillars in this context. These elements collectively lay the foundation for establishing a balance among the three key stakeholders, thereby fostering an environment in which the adolescent can develop their maturity and assume their own role in the care process. When considering the legislation in the Netherlands, which employs an age limit as a criterion, it becomes apparent that there is limited enthusiasm for this approach. Both general practitioners and adolescents express the view that actively involving a parent, even from the age of 16, does not impede the autonomy of the adolescent; instead, it can be of significant added value. This perspective holds true not only at a practical level but also in terms of building trust. The personalized approach and motivational support that parents provide clearly work in favour of the physician, as was also evident in the interviews. Dealing with the adolescent brain or behaviour is a conscious effort for many. This involves a strong emphasis on actively building trust and motivating the adolescent, achieved through logical and affective approaches, a preference for outcome-oriented work, the reduction of intervention duration, and an active follow-up. During the research, several bottlenecks were identified that complicate daily practice (depicted in figure 1).

Challenge 1: Poor knowledge of the legal framework

From the discussions and active exploration of knowledge of the Patient Rights Act, a lack of awareness in all parties about this regulation emerged, which manifested as uncertainty and making assumptions. Particularly, an adolescent with doubts about medical confidentiality may not be inclined to seek medical care. Furthermore, when doctors and parents hold different expectations regarding these rights, inadequate communication may foster future frustrations and uncertainties. During a medical consultation, transparency regarding the applicable laws can be the solution. It is important that doctors explicitly address the legislation to which they adhere for both parents and adolescents. Physicians also hope to be endorsed by the Order of Physicians when needed. Parents may appreciate a physician choosing to speak to the adolescent separately, as long as the reasoning behind the choice and acknowledgment of the ongoing role of the parent are provided. If desired, and with the adolescent's consent, relevant information can be shared with the parent to ensure the continuity of care. Several physicians and families supported a deliberate discussion of this issue, both within the family and in consultation with the general practitioner.

TABLE 2: Interview script: focus discussion with general practitioners.

STOP	• What habits or actions do we repeatedly engage in that aren't effective? • What should we stop doing?
START	• What are we currently not doing but should be? • What would be the most valuable action to begin with?
CONTINUE	• What is working well? • What should we continue doing?
ADJUST	• What should we keep doing but in a different way? • What adjustments would be most beneficial?

Challenge 2: Passive role of the adolescent

Most adolescents did not feel actively involved in medical matters, especially if they are not chronically ill and do not have frequent interactions with a general practitioner. In the presence of a parent, they tend to take on a more passive role, potentially losing awareness of the relevance of their own opinions, and the opportunity for engagement remains underutilized. This primarily widens the gap between the general practitioner and the adolescent, resulting in hesitancy to discuss matters with the physician. This barrier hinders progress toward adulthood and can even impede the transition to independence when reaching the age of 18. The successful approach, as repeatedly emphasized by the participants, involves an active strategy where the adolescent is directly addressed and engaged. Effective involvement of the adolescent includes personal addressing and finding common ground. Even small gestures, such as a thoughtful opening addressed to the adolescents, contribute to the value placed on their opinions, which can significantly enhance the treatment process. Physicians and parents observed that there should be proactive consideration of this involvement, even in the absence of an immediate need. Waiting for problems to arise before involving the adolescent is not optimal. Initiating dialogue with the adolescent while considering potential future challenges can facilitate their personal development and create opportunities.

Challenge 3: Parenting Style

A potential problem for parents is their prominent presence during consultations, where parents often default to their automatic reflexes. Parents consider it unnatural to release their child, when this is coupled with the potential difficulty for the adolescent to request a private conversation with the doctor it can result in the continued hierarchic position of the parent. In certain situations, it can have a negative impact on the disease process, such as in the case of an eating disorder where a parent plays a causal role. As some participants emphasize, each family has its own dynamics, and it is essential to consider and address the hierarchic relationship between parent and child separately. This allows the general practitioner to assess the situation and identify the interests of each involved party. However, it is important to not rush the separation, as adolescents also emphasize the value of the presence of a parent, ranging from practical assistance to moral support. The key is to find a balance between being present and giving space in parenting, especially in the follow-up of care or mental health issues. As mentioned previously, not every adolescent will explicitly indicate the desire for time alone with the physician. Here, the value of the physician's guiding role following a critical analysis is evident. Many parents and adolescents expect this role, provided there is good communication and a recognition of the parent's role.

Challenge 4: Loss of a broader perspective on the family

General practitioners often consider it a significant advantage to know the entire family, witness the adolescent's growth, and take the necessary time to understand the adolescent and the context. However, this broad view of the entire family can be at risk due to the emergence of group practices, increasing waiting times, reduced home visits, and the overall complexity of care in urban areas. In many group practices, efforts are made to address this

TABLE 3: Interview script: semi-structured interviews with families.

Basic information	*Directed to the child:* How old are you? How many siblings do you have? Are you the youngest, middle, or oldest child? Where do you live? *Directed to the parent*: Do you work in healthcare?
General autonomy of the adolescent	*Directed to child and parent*: At what age does an adolescent take full responsibility for their schoolwork? At what age are you allowed to choose your own hobbies and extracurricular activities? At what age is an adolescent allowed to attend certain activities independently, such as school or after-school programs? Do you agree on what time the child should be home after school, extracurricular activities, or going out? How are these agreements made between adolescents and parents? At what age is an adolescent allowed to go on vacation without their parents? At what age does a child start managing their own budget? *Directed to the child*: Do you have a student job? If so, at what age did you start?
Medical behavior of adolescent and parent/ guardian	*Directed to child and parent*: How frequent is the adolescent ill? How regularly do you visit a family doctor? Do you go to same GP? Does conflict arise about medical decisions, such as whether to visit the GP alone or not? *Directed to the child*: Are you currently receiving treatment for anything? If so, did you have a say in choosing that treatment? Who made the final decision? As an adolescent, how comfortable do you feel discussing your health with your parents? D*irected to the parent*: As parents, how comfortable do you feel discussing your health with the adolescent?
Medical autonomy	*Directed to the child*: Scenario 1: You come back home from school, your parents are at work and you feel very ill (heavy cough, fever). A. You call the doctor yourself and try to make an appointment. B. You call your parent asking to contact the doctor. You go to the doctor yourself. C. You call your parent for advice. You go to the doctor together. D. You wait until your parents are home to have them call the doctor. Scenario 2: You come back home from school, your parents are traveling and you feel very ill. You are staying with friends/ family A. You call the doctor yourself and try to make an appointment. B. You ask your parents/family to contact the doctor. You go to the doctor yourself. C. You ask your family for advice. You go to the doctor together. D. You wait until your parents are home to have them call the doctor Scenario 3: You are currently at the doctor's office with your parent. You have a medical question and would rather get advice from a doctor before talking to your parents. What do you do? A. You ask the question anyway, in front of your parent/guardian. B. You don't ask the question, because your parent/guardian is present. C. You don't ask the doctor if the conversation can continue without your parent/guardian present, because you are afraid the doctor will say something to your parent/guardian. D. You ask the doctor if the conversation can continue without your parent/guardian present. Scenario 4: You have a sports accident and a treatment plan is drawn up at the doctor's office in consultation with your parents. However, you disagree. What do you do? A. You remain silent during the consultation and follow the treatment plan. B. You remain silent during the consultation, but do not follow the treatment plan C. You remain silent during the consultation, but you tell your parents at home that you disagree D. You show during the consultation that you disagree, choose a plan that is more convenient for you together with parent/doctor, and follow this treatment plan
Knowledge of medical laws	*Directed to the child, the parent may step in if the child is in doub*t: Are you aware of the medical laws? How important is it to you that these laws exist? How consciously do you deal with them? *Directed to the paren*t: As a parent, how do you view the level of autonomy your child assumes/how they handle it? What role do you think parents should have in making medical decisions? How do you deal with this? In what ways do you try to get the adolescent to take on that role (how do you involve him)? Are there any specific challenges or concerns you experience as a parent in balancing that medical autonomy with your parental involvement? *Directed to child and paren*t: Do you feel that the adolescent is involved by the health care provider, for example, the doctor or nurse? What role should the caregiver take in the child's care?
Conclusion	After this conversation, do you notice a difference between child autonomy at the general level and at the medical level? If that's the case, what do you think causes this? Why does it happen? Will you handle autonomy or participation differently after this conversation?

challenge through briefings in which the family situation is outlined. One practice even emphasized the preference to have adolescents under 16 years old attend their first appointment with a parent. A thorough knowledge of the broader family context by the physician sheds light on the situation and prevents uncertainties.

Discussion

This study explored the perceptions of adolescents, parents, and physicians regarding the current legal framework of medical decision making and the representation of minors (specifically adolescents). Key themes such as trust, responsibility, and open communication (previously identified in studies by Donck et al, 2023 and Song et al, 2019), also emerged in this research (11, 13). However, we provide a more in-depth analysis of these topics by interviewing all involved parties. Overall, the results indicate that the current system adequately addresses the needs and capacities of adolescents. Physicians demonstrate an understanding of adolescent cognitive, emotional, and social maturation, aligning with prior research (3). Nevertheless, potential challenges within daily clinical practice were identified. This research reveals a lack of knowledge about regulations and doubts about their application, consistent with previous studies (14, 15). There is consensus on the importance of confidentiality for adolescents as it contributes to their sense of security (13). While the advantages of confidentiality with healthcare providers are evident, there is disagreement and therefore uncertainty regarding the sharing of information with parents (8, 16, 17). Particularly given the lack of knowledge among adolescents and parents about the rules or uncertainty about the parent's expectations (18, 19).

Adolescents should not only feel safe but also heard during a consultation. A recurring theme is that adolescents sometimes feel inhibited to speak or address certain topics, despite the fundamental trust in their doctor (20, 21). While previous research is scarce, our study indicates that actively acknowledging or questioning this hesitancy can be an effective strategy. Furthermore, some parents emphasized the importance of a positive role model, as previously investigated by Miller et al. Adolescents find this role model in a parent, sibling, or even in their doctor. Identifying common ground and thus motivating the adolescent can certainly contribute to better communication (22). In this context, the importance of proactive care is stressed. It makes little sense to wait until problems arise when adolescents can learn early on to discuss concerns with a doctor and feel that their perspective is valued (13). Promoting this awareness and creating an environment that encourages open communication contributes to a healthy relationship between the adolescent and the doctor.

Another variable in an adolescent's life is the presence of a parent and their parenting style. Research indicates that a parent's caregiving has positive effects on a child's mental health (17, 23). Detaching a child from a parent too early is rarely the best way forward and consensus on the age at which an adolescent can be seen alone lies between 16-18 years (13). The complexity of parent-child dynamics is also present in healthcare settings. Our interviews reinforced this complexity: while children generally felt more at ease for the online interviews in the presence of their parents, they could also be more reserved in answering certain questions, though this probably varies with individual personalities. The advantage of joint interviews was that we could observe the parent-child dynamic directly and observed a deeper reflection on the part of the participants due to their interpersonal exchanges... However, the boundary between parental caregiving and controlling is not always clear and can have adverse effects (24, 25). Within our existing legal framework, there exists a grey area where empathetic engagement from the part of the physician can assist in determining the most suitable approach for each unique situation.

To better understand this dynamic, considering the broader family context and the child's situation can be a contributing element. While general practitioners feel strongly about this, it could become a skill they risk losing due to the decline in home visits and the expansion of group practices, where family members are occasionally seen by other doctors (26). As one of the participants put it: "Illness experiences and disease patterns are heritably transferable but are also transferable in a social context." The home environment and parental medical behaviour significantly impact the adolescent's well-being and should not be overlooked (27, 28).

This study has several limitations. Firstly, the sample size is relatively small as is often the case in qualitative research, which could restrict diversity in responses or experiences, which can limit the richness of the data. We maintained group sizes consistent with adequate sampling, involving 10 general practitioners, 12 children, and 10 parents (29). Additionally, there is potential for selection bias, as only one father participated and 70% of the general practitioners worked in group practices. The parents and general practitioners who agreed to participate may have had different perspectives than those who declined. Furthermore, the use of case-based surveys presents some limitations, such as the subjective interpretation of the case by the participant and the limited generalizability of the research results to other situations or cases. Yet, quantitative research provides participants with the opportunity to critically reflect on the case without direct influence from the researcher (30). Finally, important to note is that we did not actively account for variables such as educational levels, religious beliefs, and cultural differences. For future studies, addressing these limitations will be crucial and provide opportunities for further research. Aspects such as culture and socioeconomic status deserve more attention to achieve a more accurate reflection of our diverse society.

To conclude, a brief self-reflection: The same person conducted all the interviews and prepared the transcripts. This ensured consistency in data collection and allowed for the comparison of non-verbal cues and contextual factors. However, it also implied a risk of subjectivity and bias due to the researcher's personal expectations, a potential decline in quality due to the high workload of transcriptions and interviews, and limited variation in questioning and follow-up prompts.

Conclusion

We chose a qualitative research approach to deeply explore adolescents attending medical appointments alone or with their parents, as well as general practitioners' decisions regarding parental presence. While enriching, previous studies extensively cover this topic. Focusing on specific areas of improvement enhances the relevance of our research, highlighting the complexity of interactions among physicians, parents, and adolescents. A deliberate approach, clear communication, and active involvement of all parties are crucial for maintaining a balanced healthcare system. This prompts further investigation into potential solutions: Can promoting communication increase knowledge about laws? Does actively encouraging and expecting adolescent involvement improve their understanding of their role in medical contexts? Can physicians, through empathy, discern between caregiving and controlling parental roles? Can discussing the entire context enhance the quality of care for adolescents?

The authors declare that there are no conflicts of interest with regards to the acquisition and reporting of the data of the study presented in this manuscript, all procedures were in line with the editorial policy of the Belgian Journal of Paediatrics.

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