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Upcoming Issues of *Virtual Mentor*

April: Professional Self-Regulation
May: The Role in Faith in the Patient-Physician Relationship
June: Ethics in Family Medicine

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Adolescent Health and Medical Ethics

Few patient age groups are able to spark controversy the way adolescents can. There is even debate over which patients should be included in this group (Does adolescence begin at puberty? At age 13? Does it end at age 18? After college?). A second controversy surrounds the question of which medical specialties should rightly be involved in treating teenage patients (pediatricians? family practice? internal medicine? adolescent specialists? adult or pediatric subspecialties?). Given the range of ages as well as medical specialties involved in the care of teens, the ethical dilemmas raised in this issue of *Virtual Mentor* should resonate with nearly every physician in every specialty.

One reason that adolescents are such a fascinating patient group is their in-between status. They are not children and not yet adults. We want adolescents to become competent decision makers as adults, and this requires allowing them to participate as teenagers in decisions that affect them. However, we know that adolescents do not always make the best decisions. Adolescents participate in a wide range of risky behaviors: 42 percent have gambled, 45.6 percent have smoked marijuana, 51.2 percent have smoked cigarettes, and 75.6 percent have consumed alcoholic beverages [1]. The adolescent desire for privacy and independence balanced with the knowledge that adolescents are not fully mature raises 3 ethical issues: consent, confidentiality, and decision-making capacity. All 3 issues are addressed in this month's *Virtual Mentor*.

The issue of consent comes up whenever physicians must consider whether a patient is able to make decisions independent of parental permission. In Case 1, a physician must weigh the refusal of a teen patient against his parents' wishes for a drug test. Our OpEd section presents 2 opinion pieces on the topic of consent, discussing whether it is appropriate for physicians to accept teen consent for cosmetic plastic surgery, a situation that may be increasingly common given the success of television make-over shows such as "The Swan."

Adolescents often confide information to their physicians that they do not wish disclosed to their parents or caregivers. In case 2, a physician is faced with a patient who confesses to an eating disorder and wishes to keep it secret. The policy forum picks up this topic in its review of current policies and best practices in handling confidentiality in teen patients with substance abuse.

The third critical topic is adolescents' ability to make decisions for themselves and their health care. Case 3 concerns a teenage patient with a chronic disease and the factors involved in deciding whether she is ready to make the transition to adult subspecialists.

In addition to the 3 basic ethical dilemmas outlined above, this issue also addresses the more subtle difficulties that many physicians have when they come face to face with adolescent patients. In our clinical pearl, Rachel Katzenellenbogen offers a handy mnemonic to use when interviewing teen patients. It ensures that you have explored all major aspects of a teenager's life that affect his or her health. In the medical education section, Maurice Clifton and Alda Gonzaga discuss various ways that medical schools can provide their students with the knowledge and skills that are invaluable in working with adolescents.

Looking at current trends in law that affect the health of adolescents, Kate Karas expresses concern over statutes that would force physicians to report all occurrences of sexual activity among minors to social services as "child abuse." These statutes would usurp the role of physicians in determining whether harm has or has not taken place.

Our journal discussion, policy forums, and medical humanities sections explore 3 other areas that can profoundly affect the adolescent population. Louis Kraus and Renee Mehlinger provide a comprehensive look at treatment of adolescent depression and how the FDA's black box warning may impact therapy. Robert Morris takes an in-depth look at the health care needs and problems of incarcerated teenagers. Alli Grady reviews a published first-person account of the struggles teenagers face when coping with nascent problems of gender identity, a topic of increasing relevance today.

Last, when considering which subspecialists are involved in the care of teenagers, we offer a historical look at the emergence of adolescent medicine as a new specialty. We describe the context in which this specialty developed, and hint at its future as a subspecialty of medicine.

In viewing this month's issue as a whole, we have endeavored to bring together articles that examine ethical dilemmas affecting specific populations of at-risk teenagers, dilemmas such as eating disorders, substance abuse, incarceration, and depression. In reading these articles, you will find themes of consent and confidentiality that are applicable to every teenager that you may meet. Overall, we hope you will come away with a better understanding of the challenges facing adolescents and some ideas about how to address them more effectively with your own patients.

The learning objectives for this issue are:

1. Understand the importance? and limits? of confidentiality in treating adolescent patients.
2. Learn methods for appropriately reviewing all biopsychosocial systems with adolescent patients.
3. Learn the history, circumstances, and need for the emergence of adolescent medicine as a specialty.
4. Understand the skills needed by physicians when dealing with adolescent patients and how medical schools can provide these within a 4-year curriculum.

5. Identify circumstances in which adolescent patients' abilities to consent for their own care are controversial, such as in plastic surgery, management of an eating disorder, and ability to manage a chronic illness.
6. Learn the factors involved in determining whether an adolescent patient is ready for the transition to adult specialty care.
7. Learn the best approach and treatment for adolescent depression and the impact that the black box warning has had on treating depression.
8. Understand the challenges and rewards involved in caring for adolescent patients who are incarcerated.

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Clinical Case
Drug Testing in Adolescents
Commentary by Todd S. Varness, MD, MPH, and Norman Fost, MD, MPH

Adam Smith has been under the pediatric care of Dr Bernice Nichols for the last 7 years, since his family moved to town. He has been an average student and plays football and baseball. He has had no major health problems to date and is, to all appearances, a healthy 15-year-old. He has 2 younger siblings and very involved parents, Beth and David.

Dr Nichols saw that Adam was on the clinic schedule with a 2 PM appointment; the chief complaint listed was simply "concerns." She quickly checked his chart. He was last seen 9 months ago for a sports physical and everything was normal. Her notes say that he was "a little more quiet than usual, but talked about baseball when asked." As Adam was escorted into an exam room with his parents, he appeared sullen and replied in one-word answers to the nurse's jovial greeting and questions. His parents appeared anxious.

Dr Nichols greeted both Adam and his parents and asked what brought them in. Adam stared at the floor. His parents shifted uncomfortably in their chairs, and then David replied, "We'd like a drug test on Adam."

The parents explained that Adam, previously a cheerful and garrulous boy, had become more withdrawn and sullen the past few months. Since he started high school his circle of friends had changed, and they feared he was hanging out with a "bad crowd." In the past his grades had been Bs, but had now dropped to mostly Cs. Both parents were convinced that Adam was doing drugs and were desperate to get him help. They begged Dr Nichols to perform a drug test so that they would have proof he was doing drugs and could get some help.

Dr Nichols asked Adam, "How do you feel about what you have just heard?" He replied: "I'm not on drugs. I don't want the test."
"Well, how about a basic check-up?" Dr Nichols asked. With Adam's permission, Dr Nichols performed a physical on Adam and everything, including the neurologic exam, was normal.

Dr Nichols asked the parents what made them think that Adam was doing drugs. They explained that the change in friends had them very concerned. They stated that sometimes he came home from nights out with his friends and looked "a little strange." One of the friends that Adam occasionally spent time with was older and recently had a major car accident. The Smiths feared it was drug- or alcohol-related.

They explained that Adam spent a lot of time in his room when he was home, whereas he used to spend more time interacting with the family.

The situation had come to a head the previous weekend after Adam arrived home from a night out with friends. The next morning his mother went to do his laundry and thought that his clothes smelled strange, possibly like marijuana. His parents asked Adam about this, and he denied using the drug but explained that some of his friends did use it and that was probably what made his clothes smell bad.

Dr Nichols knows that changes in behavior, grades, and friends are all suggestive of possible drug use. She also knows that Adam's behavior and exam do not suggest that he is currently on drugs. What should she do?

Commentary

by Todd S. Varness, MD, MPH, and Norman Fost, MD, MPH

Adam's parents have appropriately identified changes in his behavior, grades, and friends that might indicate drug use, and they appear to be motivated to help him rather than to punish him. Despite their apparently good intentions, however, their request to test Adam for drugs without his consent raises ethical issues involving competence, consent, confidentiality, and paternalism.

Competence

The American Academy of Pediatrics (AAP) policy statement on testing for drugs in adolescents states: "Involuntary testing is not appropriate in adolescents with decisional capacity—even with parental consent—and should be performed only if there are strong medical or legal reasons to do so" [1]. Definitions of decisional capacity, or competence, vary widely [2]. The AAP policy states that competency "refers to the patient's ability to understand the relationship between the use of a drug, its consequences, and testing" [1].

This definition, like most, relies on overall cognitive functioning and developmental status, as opposed to age. Age is a poor proxy for the determination of competence, since there is such variability in the age at which one achieves the ability for abstract reasoning. The acquisition of abstract reasoning occurs gradually and in some cases never occurs. Therefore, it is necessary to make this determination on a case-by-case basis [3]. We assume that Adam would meet most standards for competence.

Consent

If Adam is competent then his consent is required [4]. An acutely intoxicated individual might not have decisional capacity, and in that case a urine drug test could be conducted without consent as part of the medical evaluation. But there is no reason to suspect Adam is intoxicated at this time, and, even if he were, there does not appear to be an emergency, so consideration of testing could be delayed until he regained capacity.

Confidentiality

Confidential health care is commonly offered to adolescents because of their cognitive development but also because of the prevalence of high-risk behaviors in teenagers. Adolescents are less likely to seek care if they perceive that health care services are not confidential [3]. An exception might occur if there were an imminent threat of serious harm to the patient or others, but that does not seem to be present at the time of Adam's visit. Statutory requirements for breaching confidentiality, such as reporting of suspected child abuse or contagious diseases, would also be exceptions. If there were a compelling argument for breaching the presumption of confidentiality, the adolescent should have the opportunity to assist in how the parents are to be informed [3].

Paternalism

As the AAP policy on consent states, reasonable efforts should be made to include the pediatric patient in health care decisions [4]. As with adults, there are situations when it may be necessary to violate a patient's autonomy, either because he is not competent or there is a substantial risk of harm to self or others [5].

As Silber suggested, "Paternalism can be justified when the evil prevented is greater than the wrong caused by the violation of the moral rule and, more importantly, if it can be universally justified under relevantly similar circumstances always to treat persons in this way" [5]. Few competent adults would support a paternalistic policy of involuntary testing in this situation.

Good Ethics Starts with Good Facts

Good ethics starts with good facts, and there are a number of important considerations about the specifics of this case. First, a urine drug test in this setting could be falsely negative. The specimen might be obtained too late after the most recent drug exposure, or the quantitative threshold for a positive test could be higher than the patient's drug level. Furthermore, several psychoactive drugs (eg, "ecstasy," inhalants, "designer drugs") are not tested in standard urine drug screens [6]. Therefore, a negative test would not eliminate concerns regarding the possibility of a substance abuse problem. A positive screening test would provide laboratory confirmation of the recent use of some psychoactive drugs, but would not distinguish the frequency, pattern, or extent of drug use [6]. In this sense, a urine drug test is only a small part of a substance abuse assessment and often is not required at all.

Even a positive test will be helpful only if it leads to a successful intervention. How well do treatment programs work, and, more importantly, how well do they work when the adolescent is participating involuntarily?

Treatment programs for adolescent substance abuse vary in their modality, setting, and level of care, and the selection of a program is usually tailored to the severity of the adolescent substance abuse disorder [7]. Although many of these programs have been associated with some short-term and long-term reductions in substance use, there are still significant rates of relapse and noncompletion [8]. No studies to our knowledge assess the effectiveness of treatment programs when the adolescent is participating involuntarily. The prevailing wisdom, however, is that involuntary participation is less likely to be effective than voluntary participation.

Suggested Course of Action

If Adam is incompetent or is acutely impaired at the time of the evaluation, then a drug test without his consent could be justified as part of a diagnostic evaluation essential to protecting his health. But Adam does not appear to be acutely intoxicated and is presumably competent. Violation of his autonomy could be justified if he appeared to be at risk of imminent harm and the violation had a reasonable chance of success in addressing his problems. However, we do not have evidence of likely benefit, particularly if he were forced to be tested and undergo treatment against his will. The likelihood of benefit is an empirical question, and data are inadequate to make a confident judgment of success. The default position is "First, do no harm" and respect the fundamental obligations of obtaining consent and respecting confidentiality. The burden is on the health care professional to overcome this presumption, and there does not seem to be a compelling argument to do so in this case.

Furthermore, such a violation could jeopardize the patient-physician relationship and may deter Adam from seeking appropriate health care services in the future, resulting in further harm to his interests.

In summary, a positive urine drug test will have uncertain benefits, and a negative test would not provide reassurance that Adam is not using drugs. Because we are not able to appropriately justify the violation of Adam's autonomy, a urine drug test should not be performed on him without his consent.

That said, Dr Nichols still has an obligation and other opportunities to help Adam. After a discussion with Adam and his parents, she should offer a confidential interview with Adam. The goals would be to obtain a meaningful history of drug use and to identify his attitude toward drug use, the use patterns of his friends, risk factors for future drug use, the presence of co-morbid conditions, and the presence of other risky behaviors [9].

Depending on the results of this interview, Dr Nichols should encourage him to share this information with his parents, with her help as a facilitator. Regardless of a disclosure by Adam, he should be encouraged to talk with his parents more extensively about his friends, state of mind, and attitudes about drug use. Since Adam's history is indicative of possible drug use, Dr Nichols should consider referral to a qualified mental health professional to determine the need for further diagnostic evaluation or treatment [10]. It is in Adam's interest to elucidate the cause of his recent behavior changes, as well as to take reasonable steps to assure his parents that he is addressing their concerns.

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Clinical Case
An Adolescent with an Eating Disorder
Commentary by Garry Sigman, MD

Carli Fisher recently made an appointment for her yearly physical with Dr Ben Goldstein. Dr Goldstein always enjoyed seeing Carli, a motivated and responsible teenager who, at 17, seemed to have direction and plans for her future. In accordance with Dr Goldstein's office protocol, Carli's mother remained in the waiting room during the visit.

During the interview, Carli was bubbly and vivacious. She enjoyed school and was looking forward to college. She had lots of friends, but no steady boyfriend. She played tennis and soccer. She explained that she had recently developed an interest in baking and had won a prize in a school contest for a cherry pie. When asked if she had any concerns, she explained that she was trying to "take off a little weight" that she gained after the soccer season. She also stated that she had occasional headaches, but she attributed them to stress about taking the SATs. Otherwise, she had no health concerns.

Dr Goldstein noted that Carli had lost about 7 pounds since her last visit 6 months ago, but she did not appear grossly underweight. During the HEENT exam, Dr Goldstein saw some dental enamel erosion on the posterior surfaces of her teeth. He also detected mild enlargement of her parotid glands bilaterally. Her cardiovascular and pulmonary exams were normal. On abdominal exam, Carli complained of mild nausea with deep palpation, but no masses or painful areas were found. Her neurologic, musculoskeletal, and genitourinary exams were normal. She had mild facial acne. Dr Goldstein also noted a callus on her right middle finger. Carli explained that she has developed that callus "from all the writing that I have to do in my English class. We write long essays!"

After completing the physical, Dr Goldstein explained to Carli that he was concerned about bulimia. At first, Carli flatly denied any binge-purge behavior. Dr Goldstein suggested that Carli go down the hall to the lab and give a blood sample so he could get some screening labs. Carli seemed worried. "Do you think something's wrong with me?" she asked. Dr Goldstein said he just wanted to make sure nothing *was* wrong, and Carli agreed to the test.

Not long afterward, Dr Goldstein's nurse called Carli back in from the waiting room where she had been working on school assignments. Her screening blood work showed mild hypokalemia, increased serum amylase, and a normal CBC. Dr Goldstein showed these results to Carli and explained that they were highly suggestive of bulimia. Sighing, she admitted to bingeing and purging during the past 5 months. She explained

that she would get the urge to eat and then feel as though she couldn't stop eating. Afterwards, she felt guilty and purged by vomiting. She had tried diuretics a few times but felt they were "less effective than vomiting." Carli told Dr Goldstein that she thought she was getting better. A few months ago she was bingeing and purging almost daily and she now only did it a few times a week. She begged him not to tell her mother. "My mom is under a lot of stress right now since her sister was diagnosed with cancer, and I don't want her stressed out with my problems," she explained. She promised to work with Dr Goldstein to stop her behavior as long as he did not tell her mother. Carli promised to come in for weekly weight checks and exams or do "whatever," so long as Dr Goldstein kept her secret.

Dr Goldstein was concerned about Carli. He knew that her physical manifestations and lab values showed that she was probably sicker than she realized. However, she was 17 and had been a reliable patient in the past.

Commentary
by Garry Sigman, MD

This case fits into the most common and paradigmatic ethical dilemma that arises in the health care of adolescents. It is a struggle between the adolescent's need and request for autonomy? the moral imperative of a clinician to respect a person's autonomy? and the parents' need and requirement to know about and understand their children's thoughts, attitudes, and behaviors. The moral imperative of parents is to care for adolescents as they grow toward adulthood. Dilemmas like the one in this case often seem insoluble. It sometimes seems there is no right approach to take without doing harm as well as good. I will examine the process and desired outcome to best guide us in this dilemma.

Process
Confidentiality and consent issues frequently arise while providing health care to adolescents. These are compelling aspects of the *process* of adolescent medical care. Two age-related characteristics of adolescents inform the case.

1. A unique characteristic of adolescents in a health care setting is the intense desire for privacy and autonomy. Failing to provide a confidential patient-physician relationship and private environment will result in failure to learn necessary information about adolescent patients [1]. Dr Goldstein's skill in this area led to the initial discovery of Carli's illness. An emerging adult like Carli needs to be respected, however, and treated as an autonomous individual as much as possible [2]. This treatment gives her necessary life experience in managing herself—in listening, in learning, in communicating, and in making decisions.

2. Although adolescents deserve respect for their autonomy, they are not yet self-sufficient adults. Their cognitive abilities are equal to those of adults, and in the case of older female adolescents their physical development is equal to that of adults. Yet they still require guidance and support, both emotionally and financially. Any decision to

grant autonomy in a health care setting must be accompanied by age-appropriate interventions to help patients make decisions and to provide support [3].

Carli appears reliable, motivated, prompt, and responsible. Ultimately she is truthful with Dr Goldstein. We also learn that her mother's sister has cancer, adding to parental stress, and consideration of her mother's needs prompts Carli's desire for the doctor to keep his discovery "secret. " These facts compel the doctor to consider granting her request for privacy relating to her circumstances and her condition.

Outcome

An exclusive focus on the *process* would obscure realization of the ultimate desired *outcome.* What is the physician's goal for this patient beyond the question of whether Carli's mother should know about her condition? Most would agree that in this case it is to help her get well or to cure the disease and lessen the suffering that is wrought by the disease.

Carli clearly has an eating disorder syndrome consisting of weight loss, a cycle of "binge" eating, compensatory behavior in the form of diuretics and vomiting, and emotionally laden food and body weight concerns. In addition, the physical examination indicates chronicity. Hand calluses, dental enamel erosion and parotid gland enlargement only occur from prolonged behaviors that accompany eating disorders [4]. Chronicity is a key characteristic in diagnosis, indicating more than a voluntary "choice" to utilize behaviors, but a compulsive pattern, not easily stopped once developed over time.

By definition, eating disorders are chronic, obsessive, and compulsive. The susceptible person's personality characteristics, emotional coping abilities, and life experiences bring them to a state in which the eating-disordered life, with its related thoughts, feelings, and behaviors provides a numbing, dissociated way to live and to deal with uncomfortable aspects of both life and self. They are adaptive and functional; they serve a private purpose that the patient doesn't feel open to share [5].

Carli was not ready to tell anyone about her problem; her physician discovered it after she had initially lied to him. The denial period is a cardinal characteristic of all eating disorders. The same personality characteristics that make individuals susceptible make it unlikely that they will openly admit their problem to themselves or others. It is too shameful and it conflicts with the patient's need to feel and appear "perfect." Disclosure is often a necessary recovery task, because it represents recognition that the problem exists; telling others is like telling oneself, and forgiveness from others aids forgiveness of oneself. As with people who have substance abuse disorders, patients like Carli often require disclosure and support from others to sustain recovery.

The disease also causes significant physical complications. Most physicians are aware of acute (fluid and electrolyte abnormalities, GI, cardiac, and other) as well as chronic (bone, reproductive, renal, brain) complications. Carli already has hypokalemia, a potentially dangerous effect of the bing-purge cycle, should it advance. Eating disorders are serious not only because of the pervasiveness of psychosocial effects, but

because many are associated with physical disease and risk of life-threatening complications.

The best current evidence—although most in the field would consider it inadequate—suggests that a combination of cognitive behavioral therapy in individual or group settings and psychopharmacologic treatment is helpful for many with eating disorders [6]. Patients seeking help may find instead that their local health care delivery systems provide alternative forms of psychotherapy, different levels of intensity of treatment, and different philosophies of treatment, depending upon the training of local professionals and resources in the area. It is believed that the earlier treatment begins, the better the prognosis.

In summary, Carli's disease is chronic, self-sustaining, adaptive, secretive, and potentially lethal. Treatment requires psychological interventions and sometimes medicines in addition to medical monitoring for complications. It is far beyond an adolescent "lifestyle" choice; it is a serious disease state. The nature of the eating disorder is such that the stakes are too high to ignore it, or to provide less than optimal treatment.

Conclusion

Carli is an older adolescent who deserves and requires autonomy in the method by which she deals with her eating disorder. At present, however, she has a condition that must be disclosed if she is to receive the treatment resources that will be necessary. Her treatment and monitoring will include repeated blood work, psychotherapy, and perhaps nutritional therapy with other professionals. She may need intensive treatment in a hospital setting. Practical considerations will keep this from being "private" for long.

The physician can begin to educate her about the ultimate need for disclosure without unilaterally breaking her confidence. She has agreed to return to the office, so there is some time to readdress this need and to discuss how to approach telling her mother in a manner that would feel best to her. Many patients will choose to disclose during a session in the doctor's office; others prefer to do it at home. Many parents already suspect or know about their child's eating disorder but haven't been counseled about how to get involved. The physician's responsibility is not only to help bring about the disclosure, but to help the family move toward recovery.

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Clinical Case
Transition of Care

Commentary by Jonathan Spahr, MD, and Don Hayes, Jr, MD

Heather Jorgenson was born with cystic fibrosis (CF) and has been under the care of the pediatric CF team since her diagnosis. As a child, Heather was quite healthy and had few hospitalizations. At age 3 her parents divorced, and her mother remarried shortly thereafter. Heather's father has maintained limited contact with her since that time. Heather moved into an apartment with her mother and stepfather, a smoker, and it was at about that time that she began to need more hospitalizations for CF exacerbations. She has been in charge of her own medications and chest physical therapy since she was 16, when her mother felt she was "old enough to do all that herself." Heather spent so much time in the hospital during 11th grade that she failed her exams and had to repeat the year.

Heather's pediatric CF team consists of Dr Smith, as team leader, and a group of physicians, nurses, nurse practitioners, social workers, respiratory therapists, and nutritionists who closely monitor her care from multiple angles. At each clinic visit she sees several team members who provide information, support, and reinforcement of positive medical treatments.

At 19, Heather has just finished high school and is working part-time as a cashier, while living with her mother and stepfather. On her last visit to the University Pediatric CF unit, Heather talked with her pediatrician, Dr Smith, about her ambition, saying that she would like to become a veterinary assistant in the future, but that she has not yet applied to any colleges or vocational programs. Heather says that she began smoking about 2 years ago and, when Dr Smith asked about alcohol use, she said that she drinks alcohol 2 or 3 times a week. She said she does not use any other drugs and would like to quit smoking. She says she takes her prescribed medications according to directions, but her frequent hospitalizations suggest that she may be slipping in this regard. She has kept approximately half of her scheduled appointments in the CF clinic, often showing up late.

The hospital administration has put pressure on the pediatric CF team and Dr Smith to transfer Heather to the adult team—a transition that usually occurs when the patient is about 18. The hospital has received complaints from parents of patients on the pediatric unit that Heather is too old to be there. Several parents have also expressed concern about the way Heather dresses and the friends that visit her while she is on the unit. One parent claimed to smell cigarette smoke coming from Heather's room.

The pediatric CF team is concerned about Heather: her smoking and suspected noncompliance with her medication worries doctors that she could "slip through the cracks" with the less intensive monitoring that goes along with adult patient care but Dr Smith understands that Heather is no longer a child and must accept the consequences of adult decision making. When Dr Smith asked Heather how she felt about the transition, Heather said, "whatever you guys decide is fine with me."

Commentary
by Jonathan Spahr, MD, and Don Hayes, Jr, MD

The early stage of cystic fibrosis is a time of mild lung disease, and health care is provided to pediatric patients with no expectations placed on them and no questions asked. As these patients age and the disease progresses, more intensive care is needed. Suddenly, as adolescents, they face a demanding health care regimen, often placed upon them without adequate preparation. It is difficult enough in our society to be a healthy teen let alone one with CF, a condition that requires daily medical care. Therefore, compliance is a seed that must be planted early in the life of a child with CF. A lack of preparation can lead to the problems seen in Heather Jorgenson's case.

The transition from pediatric to adult cystic fibrosis care is difficult for the patient, the family, and the clinicians involved. Relationships between patients and families with the CF team may have existed for several years. Often, the intensive monitoring and care provided by the health professionals is given with little or no input by patients or families. This hand-holding approach is commonly observed, and without active involvement by patients and families it leads to the type of behavior described in this case. It is only natural that pediatric clinicians develop a nurturing relationship with patients they have known from infancy. Consequently, it is sometimes difficult for pediatricians to place responsibility on their patients as they age, and this may prevent opportunities for the patients to mature in their ability to be responsible for their own care.

Heather is now starting to make adult decisions about smoking and using alcohol, even if they are irresponsible decisions. Her actions demonstrate that she wishes to be treated as an adult and should be transferred to adult care at this time. By keeping her in the pediatric clinic, the staff will enable her to be dependent upon them for her CF care.

Heather's indifferent response about her own preferences for medical care is quite common among children beginning to move from pediatric to adult care. Health maintenance is low on the priority list for young adults, so it is not unexpected that Heather appears disengaged when it comes to matters of her health. It may be difficult for the pediatric team to let go of long-term patients with confidence that they will continue to receive good care. This phenomenon has been demonstrated in previous studies [1,2].

An Ideal Transition

The ideal method would have been to start Heather's transition years before her 18th birthday so that she would gradually be ready to take on more responsibility. For example, Heather would have been responsible for taking her medications and refilling them, making her own appointments and carrying her insurance card at the beginning of her teen years in order to become the primary party with responsibility for her health care.

As it is, we now lack the luxury of time, and, while it may be uncomfortable, the transition needs to occur for the sake of Heather's maturation process. Furthermore, Heather seems to be languishing in her pediatric clinic; only keeping half of her appointments and needing several hospitalizations in the last year. This will only continue if a change is not made.

Teams Must Meet in a Care Continuum

Another factor in Heather's transition is the relationship between the pediatric and adult CF teams. If the pediatric team has confidence in the adult team, they will feel more comfortable about the transfer. A meeting between them specifically about Heather would be beneficial, so that the pediatric team can voice their concerns and open up a line of communication that should exist throughout the transition. While there should be a specific point in time when the adult team assumes primary responsibility for Heather's CF care, the transition process should be ongoing, a continuum during which the pediatric and adult teams both contribute to the care plan, although all contact with Heather should be through the adult team only, so that she identifies them as her primary caregivers.

Transition without preparation can be a painful experience. It is important for us, as pediatric care professionals, to realize that our patients will be adults one day and that we must promote the transformation from dependent child to self-sufficient adult. Heather's case reminds us that if we allow our patients with chronic diseases to continue their dependence upon us for all aspects of their care, then we have done them a disservice. As pediatricians, we are responsible not only for providing health care to our patients, but also for making sure that they are allowed to mature into adults who can advocate for their own health care.

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Journal Discussion
Black Box Blues: Kids and Antidepressants
by Louis J. Kraus, MD, and Renee Mehlinger, MD

March J, Silva S, Petrycki S, and the Treatment for Adolescents With Depression Study (TADS) Team. Fluoxetine, cognitive behavioral therapy, and a combination for adolescents with depression: Treatment for adolescents with depression study (TADS) randomized controlled trial. *JAMA*. 2004;292:807-820.

Recent warnings about antidepressants have spurred a vigorous debate over suicide risks among children and adolescents. Prevalence rates for pediatric depression of up to 3 percent in children and 8 percent in adolescents have been reported. A lifetime prevalence rate of depression for 15 to 18 year olds is estimated at 14-15 percent [1]. According to unpublished information from the CDC's Mortality Statistics branch in 1999, more than half of the children with childhood depression will eventually attempt suicide and more than 7 percent will die as a result. Children with depression, whether taking antidepressant medications or not, are at increased risk for suicidal intent. The risk is increased for those children with bipolar disorder, prior suicide attempts, and a history of substance abuse, anxiety disorders, and other comorbid psychiatric conditions. [2, 6-7]

Over the past decade, the suicide rate has decreased significantly to approximately 2000 children and adolescents per year [2]. Despite this decrease, suicide remains the third leading cause of death among children, adolescents, and young adults under 25. According to the unpublished study by the Center for Disease Control (CDC), the incidence of suicidal ideations has dropped from 1 in 4 to 1 in 6 children per year. Controversy regarding the use of antidepressant medication in the pediatric population reached a peak in June 2003 when the FDA issued a "Do Not Use Warning" for paroxitine (Paxil) due to potential risks and concerns regarding suicidal ideation in the pediatric population [3].

Commentary on the FDA Black Box Warning
On October 15, 2004, the FDA announced new warnings and precautions to strengthen safeguards for children and adolescents treated with antidepressant medications. The "Black Box Warning," the strongest warning the FDA can issue, reported that "antidepressants increase the risk of suicidal thinking and behavior in children and adolescents with major depressive disorder (MDD) and other psychiatric disorders [4]." Anyone considering the use of a medication with a black box drug warning or any other antidepressant in a child or adolescent must balance this risk of the medication with the clinical need. Patients taking antidepressants should be observed closely for clinical deterioration, suicidality, or unusual behavior changes.

Families and caregivers should be advised of the need for close observation and communication with the prescriber.

The FDA relied on a pooled analysis of 24 short-term (4-16 week) placebo controlled trials of 9 antidepressant drugs (SSRIs and others) in children and adolescents with MDD, obsessive compulsive disorder (OCD), and other psychiatric disorders. They reported a greater risk of adverse events including suicidal thinking or behavior (suicidality) during the first few months of treatment in those receiving antidepressants. The average risk of such events on medication was 4 percent, twice the placebo risk of 2 percent. No suicides occurred in these trials. It is important to note that although a black box warning was issued, none of the 4400 pediatric study subjects committed suicide. Out of the 4400 patients studied, 78 experienced suicidal thinking or suicidal behavior.

In a letter from American Academy of Child and Adolescent Psychiatry(AACAP) President Richard M. Sarles to FDA Acting Commissioner Lester M. Crawford, October 28, 2004, the AACAP expressed concern over the current FDA black box warning, reporting that the recommendation of the FDA is not consistent with current research.

The FDA black box warning will have significant impact on primary care physicians, who often attempt to refer these patients to child and adolescent psychiatrists. There are not enough child psychiatrists, even within metropolitan areas, to serve children with mental health needs. In addition, many parents may decline the use of antidepressant medication for their children as a result of the warning. Based on the clear benefit of antidepressant medication in treating depression, as seen in current research and clinical experience, there may be an increase in pediatric morbidity and mortality related to untreated depressive episodes.

It is important to understand that the current FDA warnings do not prohibit the use of antidepressants in children. However, the current warning will likely have the negative effect of frightening many people from using antidepressants.

Overview of TADS Study

The TADS study is a multisite clinical effectiveness trial comparing the use of fluoxetine, cognitive behavioral therapy (CBT), a combination of the 2, or placebo, in the treatment of adolescents between the ages of 12 and 17 years of age with moderate to severe major depression [5]. The study, known as TADS (Treatment of Adolescents with Depression Study) is sponsored by the National Institute of Mental Health (NIMH).

Within this study, 20 percent of adolescents with moderate to severe depression expressed clinically significant suicidal ideation prior to treatment. Over the course of the study, 71 percent of the patients responded positively to a combination therapy with fluoxetine and CBT. The placebo response rate was 35 percent. The response rate for patients who were prescribed fluoxetine alone was 60.9 percent. The response rate for those receiving cognitive behavioral therapy alone was 43.2 percent.

Researchers from various sites using standardized clinical rating scales assessed patients at 6-week and 12-week intervals. Suicidal ideation decreased in those patients who received a combination of fluoxetine and cognitive behavioral therapy. Patients treated with fluoxetine alone and cognitive behavioral therapy alone continued to have suicidal ideation that did not differ significantly from the incidence in those receiving the placebo. A total of 5.55 percent of the patients had suicide-related events; however, there were no completed suicides in the study.

The TADS study involved 439 moderately to severely ill children and adolescents. Within this study, there were 7 suicide attempts (1.5 percent of the sample) and 24 "suicide related events" (5.5 percent). Of the 24 suicide-related events, 15 patients were on Prozac alone and 9 were receiving CBT or placebo, but no medication. There was no significant difference between these two groups.

In summary, the TADS study showed that 25 to 30 percent more of the patients receiving treatment with fluoxetine or a combination of fluoxetine and cognitive behavioral therapy had a positive response to treatment than was experienced by children and adolescents who were given placebo. Even under the best treatment circumstances, 29 percent of the adolescents did not respond to the prescribed treatment, a matter of concern. Based on the clinical results of the TADS study, however, the risk-benefit ratio was very positive for the treatment of pediatric depression with antidepressant medication and cognitive behavioral therapy.

One of the more interesting findings of the TADS study is that there appears to be a protective mechanism for adolescents who are on combined treatment with antidepressant medication and cognitive behavioral therapy. Children who are given antidepressant medication without cognitive behavioral therapy have a slightly greater increase in suicidal ideation than those who are on a combination of antidepressant medication and cognitive behavioral therapy. The latter group showed no increase in suicidal ideations.

The study is important because it shows the clinical efficacy of fluoxetine in treating pediatric depression. This study also shows the importance of the combined treatment with fluoxetine and CBT.

Conclusion

The results of empirical studies accepted with no theoretical framework leaves our patients at risk. The risk of children going without appropriate treatment for their underlying depression may increase the morbidity and mortality of the pediatric population suffering from depression. Although the FDA did not contraindicate the use of antidepressants except for paroxetine, it is likely that their action will affect the treatment practice of many physicians. Treatment practices regarding depression have already changed since the FDA warning. Child and adolescent psychiatrists and other physicians are commonly using fluoxetine as a first-line treatment. Physicians are also more likely to follow current FDA suggestions regarding frequency of visits, even though there is no specific research to support the frequency of face-to-face contacts.

Treating depression requires experience, research-based clinical knowledge, and an understanding of the effect of social, familial, and cultural factors. Based on current research, the most effective treatment for depression combines cognitive behavioral therapy and antidepressant medication. Although treatment with antidepressant medication may involve risks, untreated depression may have devastating consequences. The natural course of depression will continue to place children and adults at a higher risk for suicide. Physicians must use all of their clinical expertise and knowledge of the research in their treatment of the individual and the family.

At present, we need a better independent assessment of all of the current research data. Continued funding for independent research on pediatric depression is a vital necessity. Therapeutic trials of medication and a variety of psychotherapies with children of all ages are essential to ensure the appropriate management and treatment of the pediatric population with depression.

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Medical Education
Adolescent Medicine Training for Medical Students
by Maurice Clifton, MD, MSEd, and Alda Maria Gonzaga, MD

You are on duty in an ambulatory clinic and a 17-year-old comes in with a cold. He is well dressed and groomed. By looking at him, do you know if he is having unprotected sex? Or binge drinking on weekends? Or smoking cigarettes? Are you comfortable discussing these topics with him, and are you capable of doing so? If he is doing any of these things, do you know what to do? Do you know if you should share this information with his parents?

The adolescent age range is physiologically one of the healthiest times of life, but is associated with a high level of mortality and morbidity due to risk-taking behaviors. Accidents, suicide, and homicide cause 71 percent of all adolescent deaths [1]. The following statistics, based on data from the Centers for Disease Control and Prevention, bear that out.

- There is a 40 percent chance that your 17-year-old patient in clinic had more than 5 drinks in a row within the last month, and a 40 percent chance that he currently uses tobacco.
- There is a 34 percent chance that at some time he has ridden in a car with a driver who has been drinking.
- There is a 61 percent chance that he is sexually active, and he is in the age group most commonly diagnosed with sexually transmitted diseases.
- He also has a 13 percent chance of having seriously considered attempting suicide [1].

Adolescence is a time of life when patients develop habits that put them at higher risk for future chronic health concerns. The leading cause of preventable death among adults is tobacco use, a habit the vast majority of smokers started during adolescence. During the teen years, adolescents start to establish their diet and exercise habits, both of which contribute to major public health concerns like obesity and cardiovascular disease.

Unfortunately, adolescents are the largest group of individuals to underutilize preventative services [2]. They may see a physician only for a sports physical or treatment for a cold. They rarely present with a behaviorally related complaint, such as smoking or binge drinking. Therefore, something that seems as trivial as a cold may be your only opportunity to screen and provide interventions for high-risk behaviors.

When asked about risky behaviors, teens may initially feel uncomfortable talking to an unfamiliar adult. They are often unaware of their rights to confidential health care and are very concerned that what they tell a physician will be relayed to their parents. A key step in taking a history from an adolescent is to assure confidentiality by stating that discussions will remain between the doctor and the patient unless a problem becomes a threat to the patient or to others [3]. To a certain extent, state law determines which situations—statutory rape or child abuse—need to be reported to authorities. State law also dictates what services can be provided confidentially and without parental consent. Most states allow teens to consent independently to STD testing and treatment, pregnancy testing and prevention, substance abuse treatment, and mental health services.

Even when confidentiality is assured, many practicing physicians feel inadequately trained to screen and address risk-taking behaviors. Since about 1 in 7 US residents is an adolescent, physicians in virtually any specialty care for them. Only pediatrics, family medicine, and internal medicine require training in adolescent care, and pediatrics is the only residency with time dedicated to adolescent medicine [4-6]. Therefore, medical schools should take on the responsibility of teaching their students how to interact with and treat adolescents.

Teaching Adolescent Medicine

Ideally, medical schools incorporate training in adolescent medicine throughout their curricula. Since adolescent medicine focuses heavily on addressing health-related behaviors, many of which can be difficult to discuss, training should be highly experiential and case-based. During the preclinical years, adolescent medicine can be included in a patient-physician communication course and a behavioral health curriculum. During the clinical years, opportunities for encounters with adolescents are present during multiple rotations, including pediatrics, internal medicine, and family medicine, but also obstetrics and gynecology, emergency medicine, and surgery. Every opportunity to learn more about adolescents should be emphasized.

Communication

A preclinical communications course can teach students how to structure an interview with an adolescent so that it is patient-centered and sufficiently comfortable to allow discussion about sensitive topics, such as sexuality or substance abuse. The interview should start with topics the patient wants to discuss? the sports in which he or she participates, for example. While building rapport, the interviewer will discover the patient's many strengths and can provide encouragement for positive, healthy behaviors. The interviewer, having made the teen comfortable, can now address more sensitive psychosocial topics [3].

An effective way to include important psychosocial questions in the history is do a "HEADSS" review of systems. HEADSS is an acronym that stands for Home, Education/Employment, Activities, Drugs (including smoking and alcohol use), Sexuality, and Suicide/Depression. Following the HEADSS acronym, an interviewer can ask questions starting with least threatening topics and progress to the most uncomfortable or threatening topics [3]. (See Clinical Pearl in this issue.) These skills

have been successfully incorporated into curricula using standardized patient encounters or by students role-playing with each other.

Behavioral health

During a behavioral health course, students can learn how to counsel teens on their risk-taking behaviors. Teens are notorious for their selective hearing when an adult is lecturing them on how they should change, so be sure to identify the patients' own agendas with regard to their behaviors, and discuss behavioral methods such as the stages-of-change model [4]. This will allow student clinicians to help move a patient toward or through a behavior change as appropriate. There are successful programs in the literature using problem based learning methods, case studies, and standardized patients.

Clinical aspects

Adolescent care is often provided in a multidisciplinary setting. In clinical years, students should take advantage of opportunities to learn from the primary care physicians, psychiatrists, psychologists, and nutritionists who provide care to adolescents. When caring for adolescent patients, third- and fourth-year students can hone their history-taking skills, particularly with regards to adverse health behaviors. Students may also have the opportunity to practice their behavioral counseling skills. For students who desire a dedicated experience in caring for teens, most medical schools offer a fourth-year elective in adolescent medicine.

Conclusion

Adolescence is a period of great change physiologically, psychologically, and socially. Most adolescents make the transition to adulthood without major problems, and it is a time of intense self-discovery. They are filled with tremendous energy, hope for the future, and a playful outlook on life. Learning to be a positive influence and to guide a teen to healthy choices is fulfilling and fun, and it can have a lasting and important impact for the rest of the teens' lives.

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Clinical Pearl
HEADSS: The "Review of Systems" for Adolescents
by Rachel Katzenellenbogen, MD

Most adolescents have few physical health problems, so their medical issues come from risky behaviors. As physicians, we need to ask about the context of a teen's life, and the HEADSS assessment is a good guide [1]. HEADSS is an acronym for the topics that the physician wants to be sure to cover: home, education (ie, school), activities/employment, drugs, suicidality, and sex. Recently the HEADSS assessment was expanded to HEEADSSS [2] to include questions about eating and safety. I integrate safety into the other categories of the assessment, and I like to talk about eating and body image in the context of activities and exercise. Not all of the questions that follow need to be asked, but all subject areas should be covered; if a question is answered positively, continue the dialogue with follow-up questions (as noted in *italics*).

As always, it is important to discuss confidentiality and its legal boundaries when establishing rapport and before taking a history.

Home
Where do you live? How long have you lived there? Who lives at home with you? Do you have any pets? Do you feel safe at home? Do you feel safe in your neighborhood? Are there any guns or other weapons at home? *How are they stored? Do you have access to them?*

Education *(Note: Often teens are more comfortable answering questions about school than their home life, so you may choose to begin with these questions in your HEADSS assessment.)*
Where do you go to school? Have you changed schools recently? What grade are you in? What do you like or not like about school? What is your favorite or least favorite class? Do you feel safe at school? What are your grades like? What were your grades like last year? Do you have an IEP (individual education plan) in place? What do you want to do after finishing school?

Activities/Employment
What do you do for fun? What do you and your friends do together? Do you have a best friend? Are you in any clubs or teams? Do you have a job? What is your workplace environment like? Do you drive? Do you exercise? Do you feel comfortable with your body or weight? Do you feel comfortable with your eating habits? *Do you ever think about ways to lose weight? Do you ever eat in secret? Do you have a goal weight? What has been your highest weight? Your lowest weight? Have you ever thrown up to lose weight? Do you use diet pills or laxatives?*

Drugs *(Note: Often teens are more willing to talk about their friends than themselves, so it can be helpful to start with those.)*

Do any of your friends smoke or drink? Do you know anyone who smokes or drinks? Have you ever tried? Have you ever used other drugs (cocaine, methamphetamine, ecstasy, heroin)? *Have you ever used needles? How often do you drink or use drugs? Have you ever had a blackout? Have you ever done anything you later regretted when drinking?*
(Note: A good screening tool to include for drug use is the CRAFFT Questions [3], a brief screening instrument for adolescent substance abuse—2 or more yes answers suggest a serious problem.)
Have you ever ridden in a ***CAR*** *driven by someone (including yourself) who was "high" or had been using alcohol or drugs?*
Do you ever use alcohol or drugs to ***RELAX****, feel better about yourself, or fit in?*
Do you ever use alcohol or drugs while you are by yourself, ***ALONE****?*
Do you ***FORGET*** *things you did while using alcohol or drugs?*
Do your family or ***FRIENDS*** *ever tell you that you should cut down on your drinking or drug use?*
Have you ever gotten into ***TROUBLE*** *while you were using alcohol or drugs?*

Suicidality
Have you ever been so sad you thought about hurting yourself? *Have you ever tried? Do you feel sad now?* Have you ever run away from home? Have you ever cut yourself intentionally?

Sex
Have you ever dated anyone? Boys, girls, or both? Have you ever kissed anyone? Have you ever had sex? *Oral sex? Anal sex? How many sexual partners have you had? How old were you when you first had sex?* Has anyone ever touched you in a way you did not want to be touched or forced you to do something you did not want to do sexually? *Are you dating anyone now? How old is he or she? Do you like your boyfriend or girlfriend? Do you feel safe with him or her? Does your boyfriend or girlfriend ever get jealous? Has he or she ever hit you or pushed you? Are you sexually active now? When did you last have sexual intercourse? Did you use a condom with your last sexual encounter? Have you ever had a sexually transmitted infection? Have you ever been tested for HIV? Have you ever been pregnant? Have you ever traded money or drugs for sex?*

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Case in Health Law
Must Doctors Report Underage Sex as Abuse?

by Kate Karas

Medicine and politics can be contentious bed fellows. In 2003, the Kansas attorney general issued an opinion embedding physicians with law enforcement [1]. The opinion obligated a physician to report any evidence of underage sexual activity to social services, facing criminal sanctions should he or she fail to do so. The 14-year-old patient who inquired about birth control methods, the physical examination that revealed sexual activity—both occurrences mandated that the doctor breach patient confidentiality and turn the cases over to Kansas Social and Rehabilitative Services. That the activity was consensual and between age mates was immaterial.

Physicians have long been included in state child abuse reporting statutes as mandatory reporters of suspected child abuse. All states require that persons named by statute (eg parents, physicians, teachers, etc) who suspect child abuse report the case to the particular social welfare agency charged with protecting children. In every state, it is within the physician's discretion to determine when a harm has occurred, and, thus, when his or her duties under the reporting statute. Kansas Statute § 38-1522 is the local version of the national statute: it names physicians as mandatory reporters of suspected child abuse. Failure to do so is a class B misdemeanor.

In addition to the reporting requirement, Kansas Statutory Code imposes criminal penalties on those who engage in sexual intercourse with a minor younger than 14 years of age, regardless of whether the alleged perpetrator is also a minor. Prior to 2003, however, evidence of statutory rape did not give rise to physicians' liability under the Kansas Reporting Statue unless a medical professional determined that the minor had sustained harm as a result of the sexual encounter. In fact, the former advisory opinion to the Kansas Reporting Statute, issued in 1992, specifically rejected such a blanket reporting provision as contrary to the protective purpose of the statute.

Current Kansas Attorney General Phill Kline set a new course for Kansas physicians. On June 18, 2003, he issued a second advisory opinion, stating:

> Kansas law clearly provides that those who fall under the scope of the reporting requirement must report any reasonable suspicion that a child has been injured as a result of sexual abuse, which would be any time a child under the age of 14 has become pregnant. As a matter of law such child has been the victim of rape or one of the other sexual abuse crimes and such crimes are inherently injurious [1].

With this opinion, underage sexual intercourse becomes injurious per se, as a matter of law. Physician discretion is not invoked to determine whether the minor has been harmed; indeed, no medical judgment is involved. The opinion redefines the role of the physician to be that of an enforcement mechanism against statutorily illegal underage sex.

Finding this reformulation of physcians' role inimical to the treatment duty physicians have to their patients, medical professionals sued for an injunction against enforcement of the reporting scheme in the case of *Aid for Women v Foulston*. The district court granted a preliminary injunction, finding that minors possess a right to informational privacy that would be unconstitutionally compromised by the reporting statute. The final outcome of the case is pending resolution upon appeal, but developments out West offer some guidance as to how this court may ultimately find.

California offers two cases directly on point. In the 1986 case of *Planned Parenthood Affiliates of California v John Van De Kamp*, medical professionals challenged an attorney general opinion that applied the California child abuse reporting law to all sexual activity of minors under the age of 14 [2]. There, as in Kansas, a physician risked criminal liability for failure to report regardless of whether evidence of actual abuse was lacking, whether the minor was engaging in voluntary sexual conduct, and whether the activity was between age mates. The case reached the appeals level, where the judge positively affirmed 3 points of law important to physicians and health practitioners generally. First, child abuse reporting laws do not require a professional, who has no knowledge or suspicion of actual abuse, to report a minor as a child abuse victim solely because the minor is under the age of 14 and has indicated that he or she engages in voluntary, consensual sexual activity with another minor of similar age. Second, mandatory reporting of voluntary nonabusive behavior violates the right to sexual privacy guaranteed to mature minors by the California Constitution. Third, the necessitated recording of reports as envisioned by the reporting laws is in violation of informational privacy rights.

In 1988, California filed a civil complaint in *People v Stockton Pregnancy Control Medical Clinic* against a pregnancy control clinic alleging that the clinic failed to report minor pregnancies to the child protective agency in violation of the Child Abuse and Neglect Reporting Act [3]. The lower court issued an injunction prohibiting the clinic from further violating the act through failing to report. The Court of Appeal, however, reversed, holding again for health practitioners, but this time slightly narrowing the scope of the 1986 case. Specifically, the Court found that (1) the Act does not require reporting of voluntary sexual contact between minors under the age of 14 where both are of similar age, (2) reasonable suspicions of voluntary conduct between minors under the age of 14 and persons of disparate age must be reported, and (3) reporting to the child protective agency does not violate the state or federal constitutional privacy rights of minors.

The tectonic plates of policy are shifting, as evidenced by the shadow placed on the longevity of minors' currently recognized privacy rightsand the trend of California courts to increasingly narrow the protections afforded minors and their health care providers. Physicians are legitimately concerned about the implications these decisions

hold for the provision of health care to a vulnerable and in-need population as statutorily necessitated breaches of patient-physician confidentiality discourage minors from seeking health care.

Implications of this Trend for Physicians

Traditionally, the provision of medical services within the patient-physician relationship is insulated to the greatest extent possible from outside inquiry. The reasons for this are numerous but arise primarily from the recognition that medical information is intensely private, that the fiduciary relationship between patient and doctor is most conducive to administering the highest order of health care, and that it is crucial to public health in general and individual health in particular that persons in need of medical attention get it without unnecessary obstacles or burdens. Anticipated disclosure discourages treatment. An adolescent engaged in sexual activity who is on notice that his or her activities are subject to mandatory reporting under the criminal code may reject medical services, choosing as an alternative to perform her own abortion, forgo sexual counseling and birth control measures, or live with a treatable sexually transmitted disease in order to stay off the criminal radar. At the very least, criminal reporting discourages minor participation in the diagnostic process by posing negative incentives to the full disclosure of medical and sexual histories. The obstacles thus placed on a minor's access to health care and the physician's access to adequate information for treatment purposes, stemming from a breach of confidentiality, are dangerous to the patient, and they unnecessarily burden and impede a physician's ability to thoroughly exercise his or her professional responsibilities.

There are times, of course, when a breach of confidentiality is both medically and socially necessary. In *Tarasoff v Regents of the University of California* the court determined that when, in the course of treatment, a psychotherapist learns of a specific identifiable threat to a specific, identifiable third party, that psychotherapist has a duty to the third party to disclose that information to the proper authorities. As in the patient-psychotherapist relationship, there are exceptions that require disclosure of confidential information in the patient-physician relationship as well. The listed exceptions designated under child abuse reporting acts in particular are those in which the harm falling to the patient-physician relationship from the breach of trust is less than the harm attendant to a failure to report. Caring for the overall well-being of the patient, this determination is within the physician's and his or her professional administrator's purview of responsibility. Absent the named narrow circumstances, confidentiality is required as a prerequisite to guarantee adolescents access to and receipt of responsive and complete medical services. As quoted by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, and the Society for Adolescent Medicine, "Ultimately, the health risks to adolescents are so compelling that legal barriers should not stand in the way of needed health care" [4].

It is not simply access that the patient stands to lose, however. Just as fundamental to the provision of health services is the ability of the professional to exercise professional discretion, and this too is in jeopardy. Divesture of professional discretion takes 2 forms: physicians lose both diagnostic capacity and their ability to balance competing medical harms in determining the course of treatment for the patient.

As to the loss of their role in diagnosing, mandatory reporting requirements that oblige medical professionals to report all incidents of underage sexual activity regardless of individual circumstance ask physicians to accept a priori that underage sexual activity is injurious, resulting in a de facto abdication of their professional responsibilities to a nonmedical law-making body. Individual determinations of harm are out the window. If the Kansas advisory opinion is allowed to stand, not only would physicians be legally required to forgo individualized medical assessment in favor of blanket reporting, they would also be positively barred from exercising judgment regarding the treatment most effective to minimize the harm to their patients.

This is not equally true of all mandatory reporting schemes. The core difference between beneficial reporting schemes and those of the Kansas variety is that the former presuppose and rely upon medical discretion. It remains with the physician to determine when there is evidence of injury or abuse, such determination then becoming the catalyst for a report to the proper authorities. It should be noted that this system does not reward or even tolerate ignorance. If a doctor does not recognize, diagnose, and report abuse when he or she should, statutory negligence and criminal fault liability come into play as a matter of course, both on the state and federal levels.

Once a person listed under a child abuse reporting statute has filed a report, the recipient department of social services decides upon the warranted response. The practice manual for each group aids in this determination, and many, like the Kansas guide, find as cause to dismiss a report the likelihood that the suspected activity is consensual relations between age mates. When, however, there is suspicion of actual abuse and harm, the agency generally interviews the child, acquiring the permission of the parent or guardian first (unless there are reasons not to obtain such permission). The protective agency may then opt to remove the child from the home, mandate counseling services for any parties involved, and may ultimately decide to prosecute the alleged perpetrator of the abuse.

The uncertainty of follow-up in the case of age-mate sexual exploration or activity leaves physicians unable to assess the harm or benefit that would come as a result of reporting and therefore denies the physician the ability to perform the mandated duties: he or she is positively unable to make an ethical determination, required by the profession and by the AMA Code of Ethics, as to how to proceed based on his or her duty to (1) help and (2) refrain from causing harm. If the report is made and the trust relationship between patient and physician breached, what is the good that comes from the breaching? What is the harm? A physician is preemptively barred from determining, with any degree of certainty, the benefit of his or her decision, given the conflicting guides under reporting statutes and social service practice guides.

Not only, then, does the public risk facing a brigade of medical professionals who are barred from addressing and diagnosing them individually to treat their specific health care needs, but it risks undermining the role, privilege, nobility, and character of the profession itself.

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Policy Forum
Confidentiality and Consent in Adolescent Substance Abuse: An Update

by Melissa Weddle, MD, MPH, and Patricia K. Kokotailo, MD, MPH

Introduction

Privacy is essential to adolescents who seek health care. When adolescents perceive that health care services are not confidential, they report that they are less likely to seek care, particularly for reproductive health matters or substance abuse [1-8]. Clearly, delay or failure to receive care for these concerns increases the risk for complications [9].

Over the past 3 decades, our understanding of the cognitive development of adolescents and awareness of the prevalence of risk-taking behavior have led to an acceptance that we must provide confidential health services as an essential component of adolescent health care. In the United States, confidentiality, particularly with respect to sensitive issues such as reproductive health care and substance abuse, has become a well-established tradition, grounded in law, ethics, and clinical practice [10].

Legal framework

Until 50 years ago, parents had the legal right to make most decisions for their minor children. During the 1960s and 1970s, the Supreme Court established that minors have certain constitutional rights, including the right to privacy with respect to contraception and abortion [11]. During the 1970s, many states established laws that allowed minors to consent to treatment for sexually transmitted diseases [12], after it became clear that adolescent sexual activity was more widespread that previously believed. Most states subsequently added laws that allowed minors to consent to one or more of the following: alcohol and substance abuse treatment, mental health care, and contraception.

All states require parental consent for most medical care provided to minors, with several exceptions. One is provision of health care to the “emancipated minor,” generally understood to refer to the minor who is living apart from the parent and is financially independent. A minor may be considered emancipated if he or she is married, a parent, or in the military [13]. In general, an emancipated minor can consent to all health care.

Other exceptions include care for pregnancy, substance abuse, sexually transmitted diseases, mental illness, and provision of contraception. All states have laws which permit minors to consent to one or more of the listed services, but there is tremendous variability among state laws, and most states do not have laws for every situation. While state laws cover alcohol and drug abuse, some specify only one or the

other. Some states prohibit disclosure to parents, some leave this to the physician's discretion, and others require disclosure under certain circumstances. The Center for Adolescent Health and the Law recently published a compendium of state laws that address confidentiality and consent [14].

States Determine Confidentiality Rights of US Teens

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), which took effect in 2002, protects confidentiality for minors under some circumstances. Parents (and guardians) have control over health information and access to it for nonemancipated minor children except in situations (like those described above) in which minors are legally able to consent to health care. This federal law, however, defers to state laws which either allow or prohibit disclosure of confidential information to parents or guardians [15,16]. If a state law requires a physician to disclose information to a parent, HIPAA allows the physician to do so. If a state law permits, but does not require, the physician to disclose information to a parent, HIPAA allows physician discretion on the matter. If state law prohibits disclosure of information to a parent, the physician may not disclose without the minor's permission. If there is no state law, a physician has discretion about disclosing to a parent who requests information [17].

Medical organizations such as the American Academy of Pediatrics, American Medical Association, American Academy of Family Physicians, American College of Obstetricians and Gynecologists, and Society for Adolescent Medicine all have endorsed policy recommendations on adolescent confidentiality [18,19].

Clinical Framework

As mentioned previously, studies show that adolescents are less likely to seek health care for sensitive issues if they believe that their parents will be informed. Many adolescents are unaware of their right to confidential care for certain services, and many report that they have never discussed confidentiality with a health care provider [1,6]. Many adolescents choose to involve their parents in important health care decisions. Among those who do not involve parents, many have experienced violence within the family, and they fear incurring violence if they were to try [20].

When treating adolescents, physicians should discuss confidentiality at a first visit with the patient and parents. Limits to confidentiality should be explained. Parents and patients need to understand that if the adolescent poses a threat to self or others, confidentiality may be broken. In such cases, the physician should explain that this would be discussed first with the adolescent. Billing policies, medical records, and appointment notification can compromise confidentiality. Physicians should be aware of this and explain the possible breaches of confidentiality to adolescent patients and their parents. All clinic staff should understand policies about confidentiality and consent.

When screening adolescents for risk-taking behaviors, physicians should interview them without a parent present. Interviewing the patient privately, even for a minor illness, can optimize opportunities to ask about risk-taking behaviors, including

substance abuse. Most physicians prefer to have adolescents communicate with parents and involve them in important health care decisions, but they recognize that within some relationships, parents' knowledge of substance use or sexual activity can hinder the minor's treatment and might lead to punishment or abuse.

Issues Related to Substance Abuse

A common question that arises when caring for minors with suspected or identified substance abuse is: when is it appropriate to perform urine drug testing without the adolescent's consent? An adolescent with impaired mental status or one who has been involved in trauma, violence, or overdose should be tested for drug use. Testing can be a useful tool to monitor drug use in adolescents during drug treatment or maintenance programs.

In clinical practice, physicians may encounter parents who suspect drug use and request a urine drug test with or without their adolescent's consent. When this occurs, the clinician should obtain more information about the parents' concerns, and they should be informed that a positive urine test does not give information about the drug use pattern, or presence of abuse or dependence [8]. Similarly, a negative test does not indicate that the patient has not used drugs.

The minor should be questioned alone, ideally with the clinician sharing information about the parent's concerns. Minors often consent to drug testing. For minors who refuse testing, it is rarely, if ever, appropriate to test, except in the emergency situations mentioned above. Whenever the minor agrees to testing, the physician must first develop a plan for disclosure of test results to both parents and adolescent before ordering the test.

Another question often asked in relation to drug use is: when it is appropriate to screen select populations, such as athletes? In 1996 the American Academy of Pediatrics published a policy statement on testing for drugs commonly abused by children and adolescents that opposes involuntary testing of young people for such drugs [21]. In June 2002 the United States Supreme Court ruled that public schools have the authority to perform random drug tests on middle school and high school students participating in all extracurricular activities [22]. Although the White House Office of National Drug Control Policy (ONDCP) has published a guidebook designed to encourage schools to incorporate policies for all students [23], there has been controversy among physicians and other experts as to the utility of such testing as well as concerns about invasion of privacy [20]. There is little evidence of the effectiveness of school-based drug testing in the scientific literature [24, 25], and few schools have the staff or skills to implement costly testing. Interpretation of testing can also be complicated by false positives and validity questions that arise from the potential adulteration of specimens. It is anticipated that professional organizations will develop further policy statements to address the issue of rigorous scientific studies of the safety and efficacy of school-based testing

Summary

When screening and treating minors for sensitive health conditions such as substance

abuse, confidentiality should be honored whenever possible, and potential limits to confidentiality clearly explained in advance. Adolescents are able to consent to alcohol and drug treatment in most states, but involvement of the family is optimal in most cases.

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Policy Forum
Health Care for Incarcerated Adolescents: Significant Needs with Considerable Obstacles

by Robert E. Morris, MD

In 1999 an estimated 717 036 juveniles were incarcerated in the United States [1]. Many youth remain in detention a short time while others convicted of serious crimes spend years incarcerated. The Juvenile Justice and Delinquency Prevention Act of 1974 mandated that youth not be housed with adults. Nonetheless, on June 30, 2000, an estimated 7600 youths were incarcerated in adult facilities [2]. Each state defines the limits of the juvenile age range as it applies to detention practices and the choice of being tried in juvenile rather than adult court.

Health Problems of Incarcerated Youth

Many health problems afflict detained youth. Communicable diseases, especially sexually transmissible infections, hepatitis, and positive tuberculosis testing are commonly encountered [3,4]. Although human immunodeficiency virus infection (HIV) remains low in this age group, delinquent youth engage in risky behaviors [5,6] and some are infected, [4] often asymptomatically but with immune suppression. Universal HIV testing for all newly admitted youth may be wise, but debate around this issue continues because of concerns regarding coercion to agree to testing and stigmatization of HIV.

Approximately 10 percent of incarcerated girls are pregnant and 40 percent have been pregnant in the past [4]. This presents a dilemma for practitioners because of varying restrictive state laws regarding minors and abortion services as well as the individual practitioner's moral beliefs. Menstrual disorders, along with injuries [7], and orthopedic problems, gastrointestinal disorders, cancer, and dermatologic concerns also afflict these youth.

Little recent data shed any light on health screening practices of detention facilities, but in 1974 only 64 percent of juveniles were tested for TB and 53 percent for sexually transmissible infections [8]. In 33 percent of the surveyed facilities, nonmedical personnel did the screening [8].

Facilities

Correctional facilities can be divided into 2 large categories: local detention facilities and state-run institutions for longer-term incarceration. Detention facilities administered by local governments hold youth awaiting court decisions, ie, pre-adjudicated. These facilities are used for short-term punishment or until sentenced youth are transferred to long-term facilities. Some local governments operate camps and treatment programs such as mental health units. The states generally run long-

term institutions such as training schools or youth prisons. Some states use private group homes and prisons.

The federal government and court rulings have set minimal standards of care [9]. Each state, however, regulates the local facilities and may conduct inspections with variable oversight. The American Academy of Pediatrics and the Society for Adolescent Medicine have published position papers on care of juveniles in correctional facilities [10,11]. Voluntary accreditation by several national bodies such as the National Commission on Correctional Health Care and the American Correctional Association assures minimal standards but cannot assess actual day-to-day practices. In 2004 the NCCHC published an updated version of *Standards for Health Services in Juvenile Detention and Confinement Facilities* [12]. For the first time they contain 7 performance measures meant to determine the actual outcomes of health services. Despite these advances there is no universal accrediting body, nor is there universal standardization of care for incarcerated juveniles in the US.

Funding

Funding for medical and mental health services continues to be tenuous. Local governments and states must cover the cost of most health services because federal restrictions under 42 CFR 436.1004(a) do not allow inmates in detention centers to participate in Medicaid [13,14]. This regulation is often misinterpreted too broadly; juveniles in treatment facilities, in pre-adjudication group homes, in private facilities, and in small nonprofits may be eligible for Federal Financial Participation (FFP) [13]. Early and Periodic Screening and Diagnosis Treatment (EPSDT) funding provides payment for health screening. Private insurance often covers health care costs, especially if the care is off-site. Because local and state tax revenues are inconsistent, funding for juvenile corrections generally and for medical care specifically is unstable. However, when a person's freedom is limited, the limiting authority has a legal and moral obligation to provide medical and mental health services that meet community standards [9].

An Insular System

Correctional systems by their nature are closed to outside scrutiny and can become insular and unresponsive to the concerns of the community. Added to this is a perception by some that delinquents do not deserve care or are to blame for their plight. Few effective lobbying groups speak out in support of incarcerated youth. The state of Missouri is an exception in that a group of citizens is charged by state law to advocate for incarcerated youth in the state legislature. States and local jurisdictions need to enact legislation that will give the press and appropriate citizen groups access to their detention facilities.

Health Care Workers

Health care workers in these facilities face many challenges. Physical plants are often old and decaying. The health care staff may assume that the patients are difficult and unpleasant, especially if they have not been appropriately trained to deal with incarcerated youth [15]. Weak leadership, poor salaries, and onerous rules make detention health care careers undesirable. For these reasons, physicians with

inappropriate credentials are the only available caregivers in some places. Minimal rules requiring only a license to practice can result in practitioners working outside their field of expertise. Physicians employed in corrections should be trained and board certified in a primary care specialty, pediatrics, adolescent medicine, family practice, or possibly emergency medicine. Part-time employees can also create problems because of poor attendance and lack of commitment.

Many prisons are isolated, and the medical staff has little outside contact, which sometimes fosters their identification with the correctional staff and the assumption of a punitive role. A number of groups have urged affiliation with university medical systems to help maintain a focus on caring and renewal [16]. When private for-profit companies provide care they may limit access. Regardless of the size or structure of the program, the medical director should report to a health authority, not the facility correctional administrator. This prevents conflicts of interest and undue pressure to limit health care.

Other conflicts of interest exist. Medical personnel who provide care should not collect forensic evidence from youths [12], nor be involved in psychiatric or psychological evaluations regarding fitness for trial or culpability.

The medical staff's primary interest must be the welfare of each individual patient. There may also be opportunities to advocate for therapeutic rehabilitation instead of a sole institutional focus on punishment. Juvenile courts were founded to change the emphasis from retribution to rehabilitation. Recently there has been more concentration on punishment, and the medical staff should, when appropriate, act to counter this tendency.

Many systems lack relationships with outside agencies that could foster continuity of care for youths who leave detention and reenter the community. Public health departments and clinics should have arrangements to take responsibility for the care of these youth. Although probation officers may be reluctant to coordinate services, a court order can be beneficial in selective cases to ensure medical follow-up.
Each system needs a quality assessment and improvement program that is administered by separate staff whenever possible. Small facilities can hire outside experts to do the reviewing. Health care programs must demonstrate meaningful improvement in health services over time.

Research

Research in correctional facilities is regulated by the Code of Federal Regulations [17]. In the past, inappropriate research projects were conducted in prison. This practice led to severe restrictions on prisoner research. Although the protection of prisoners is paramount, too often overzealous interpretation of safeguards has led to an absence of research that would appropriately address the legitimate needs of prisoners. For instance, juvenile delinquents suffer disproportionately from abuse, trauma, and sexually transmissible infections. Progress in understanding these problems can only be made if research is permitted. Institution Review Boards (IRBs) that act autonomously and without proper training may be reluctant to authorize safe and

appropriate studies. The federal government needs to revisit the regulations and work to help IRB's make appropriate decisions.

Practitioners in correctional systems provide care to a vulnerable and needy population. This is a career that, though rewarding, can be filled with many ethical dilemmas and professional challenges.

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Medicine & Society
Adolescent Medicine: Emergence of a New Specialty

by Jessica Rieder, MD, MS, Elizabeth M. Alderman, MD,
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The essential elements behind the emergence of adolescent medicine as a medical subspecialty are the unique physical, psychological, developmental, and social needs of the adolescent. A combination of landmark scientific advances, a rapidly growing adolescent population, and societal changes over the past century have each played a role in the genesis of this new field. These changes provided the opportunity for clinicians to incorporate contributions from parent fields including endocrinology, gynecology, psychiatry, and infectious diseases that addressed the specific needs of the adolescent. The physical and hormonal changes that define puberty were elucidated as were the major psychological, cognitive, and behavioral developments that characterize the transition to adulthood. Clearly demarcating the onset of adolescence using both biologic and psychobehavioral markers helped to justify a specialty in adolescent medicine, and it emerged as a substantial scientific, clinical, and educational domain.

Key scientific advances from work primarily carried out in younger children or adults and subsequently applied to teens had a profound impact on advancing the field of adolescent medicine as a legitimate subspecialty. These advances took place, for example, in pharmacology of psychotropic medications and hormonal contraception, chronic disease management, and gynecologic diagnostic technologies.

Increasing Morbidity and Mortality Among Adolescents

While the advances of the 20th century likely contributed significantly to the 90 percent decline in population death rates from natural causes, the latter 3 decades of the century saw an increase in preventable causes of adolescent death, such as violence, automobile accidents, and suicide [1].

Societal changes in the US contributed to alarming patterns of adolescent morbidity and mortality. The post-World War II baby boom increased the number of teens in the United States from 30 million to 40 million by the early 1960s. Rejection of traditional religious, work, and interpersonal values by an increasingly independent and growing youth population in the 1960s led to more sexual experimentation, inconsistent contraceptive practices, wide use of illicit drugs, cigarettes, and alcohol, and secondary as well as postsecondary school failure.

The Women's Rights Movement, development of hormonal birth control methods, and the sexual revolution also had an indirect, yet profound, influence on the health of young adults. Many American youth seized the opportunity to express and experiment

with substance use, their sexuality, and familial and economic independence, but these behavioral trends were also associated with rising rates of sexually transmitted infections (STIs), teenage pregnancy, substance abuse, accidents, and violence. The field thus had to develop special interdisciplinary skills to address the unique intertwining of complex medical, developmental, and psychosocial issues characteristic of the adolescent patient.

Emergence of a New Subspecialty

The emergence and formalization of adolescent medicine as a subspecialty is marked by 3 phases. Phase I had its origins in the late 19th century English school system. In 1884, physicians who cared for adolescent boys in boarding schools formed the Medical Officers Schools Association [2]. Soon after WWI, medical services exclusively for college students were developed to care for the increasing numbers of youth that were away from home. By the middle of the 20th century, boarding schools in the United States also began to employ school physicians to develop comprehensive student health services.

The second phase in the development of the field began during the middle of the 20th century, when services to adolescents moved beyond the school to academic medical centers and professional and federal organizations. In 1941, the first medical symposium on adolescence was held under the auspices of the American Academy of Pediatrics (AAP). By the 1950s, the first adolescent inpatient unit was opened, as was the first academic training program in adolescent medicine at Boston Children's Hospital [3]. With the support of the federal government, adolescent medicine training programs with comprehensive inpatient, outpatient, and psychosocial support services were developed in the 1960s.

Coincident with governmental support of the specialty was a rapid evolution of health law and medical practice that acknowledged the concepts of self-consent for emancipated or mature minors, and recognized the primacy of confidentiality. These changes opened the door to the establishment of hospital-based clinics and free clinics in large urban centers dedicated to treating STIs and alcohol and substance abuse. By 1968, the Society for Adolescent Medicine was formed [3]. Subsequently, many other organizations and committees with a primary focus on adolescent health were created to support the needs of this patient group.

The third phase in the development of adolescent medicine occurred in the latter part of the 20th century with the formalization of the field of adolescent medicine and with the institutionalization of community-based, interdisciplinary adolescent medicine, preventive and treatment services in general pediatric programs, general pediatric practices, and school-based health centers. In 1978, the Task Force on Pediatric Education, formed by all the pediatric academic societies, published a report that gave prominence and legitimacy to the nascent subspecialty [4, 5]. This report led to sub-board certification, accreditation of training programs, and the emergence of formal curricula for the preparation of future clinicians and investigators. In 1979, the AAP formally organized a Section on Adolescent Health, which has provided continuing medical education in the field of adolescent medicine for the practicing pediatrician.

The American Board of Pediatrics administered the first examination for sub-board certification in adolescent medicine in 1994, and in 1998 the Accreditation Council on Graduate Medical Education, through its Pediatric Residency Review Committee process, accredited 16 adolescent medicine fellowship training programs.

Future of Adolescent Medicine

The next decade will undoubtedly bring many challenges. To highlight a few areas of scientific opportunity, expect a great deal of growth in neurobiology and vaccine development. Recent evidence suggests that the maturation of neurobiological development during adolescence takes longer than previously believed. This modification of our current understanding of the timing of adolescent decision making and social development will have far-reaching implications. The development and widespread use of vaccines to prevent herpes simplex virus, human papillomavirus, and human immunodeficiency virus infections will profoundly influence the health of adolescents. Work done in areas of serious adult diseases, such as obesity, hypertension, asthma, and diabetes will focus on research and clinical initiatives that can prevent or minimize the occurrence of these illnesses during adolescence.

Several important ethical issues relating to adolescents need attention, including gene therapy, transplantation, cloning, and genetic testing. The re-emergence of the debate about family responsibility versus adolescent autonomy will clearly influence the adolescent's right to consent and confidentiality. From a social perspective, adolescents now have access to communication tools that could exponentially increase their exposure to diverse educational, employment, and life opportunities. Teens and their families will have to acquire the skills to manage these tools prudently. Finally, the general field of adolescent medicine faces a number of complex challenges. These include the provision of clinical services to a rapidly changing and culturally diverse population of teens, the continued evolution and expansion of training programs, and the stabilization of funding streams for care, training, and research. We firmly believe that the next decade's many challenges are, in reality, profound opportunities.

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Op-Ed
Teenagers and Cosmetic Surgery
by Diana Zuckerman, PhD

In 2003, more than 223 000 cosmetic procedures were performed on patients 18 years of age or younger, and almost 39 000 were surgical procedures such as nose reshaping, breast lifts, breast augmentation, liposuction, and tummy tucks [1]. As we consider under what circumstances plastic surgery is appropriate for teens, it is important to recognize that very few studies have been conducted to examine the risks for teens of these increasingly common procedures. Research is especially needed for the more controversial procedures such as breast implants, liposuction, and genital plastic surgery.

There is no question that reconstructive surgeries can benefit children and youth. Surgical procedures to correct cleft lips and palates, for example, are not controversial. Plastic surgery to correct unattractive facial features that can attract ridicule from other children, such as prominent noses and ears, are generally accepted in the United States. Cultural phenomena such as surgical makeovers on numerous television programs, however, make it increasingly difficult to agree on what constitutes a "normal" appearance and when the desire to improve one's appearance is questionable or even crosses the line to psychopathology [2]. In this commentary, I will focus on elective, cosmetic procedures on an otherwise healthy adolescent with no illness or defect.

Plastic Surgery in a Developing Teen
One of the concerns about plastic surgery on adolescents is that their bodies are still maturing. In addition to development that may occur in the late teens, growth charts indicate that the average girl gains weight between the ages of 18 and 21, and that is likely to change her desire or need for breast augmentation as well as liposuction. There are no epidemiological studies or clinical trials on the safety and long-term risks of these procedures for adolescents. Although the FDA approved saline breast implants for women ages 18 and older [3], it is legal for physicians to perform breast augmentation for anyone under 18 as an "off-label" use, and the number of teens 18 and younger undergoing breast augmentation tripled from 2002 to 2003. It was not until December 2004 that the American Society of Plastic Surgeons stated an official position against breast augmentation for patients under 18.

Understanding the Risks of Surgery
Will adolescents who want to improve their appearance rationally consider the risks? Studies by implant manufacturers report that most women have at least one serious complication within the first 3 years, including infection, hematomas and seromas, capsular contracture (a sometimes painful hardening of the breasts), loss of nipple sensation, and hypertrophic scarring [4]. Since breast implants typically last 10 years,

an adolescent will require repeated surgeries throughout her lifetime [4]. Breast implants also interfere with mammography and increase the likelihood of insufficient lactation when a woman tries to breast-feed.

The economic costs of surgery are substantial, since corrective surgery is rarely covered by health insurance. With many plastic surgeons offering breast implants on the installment plan, our Center (National Research Center for Women and Families) is contacted regularly by young women who need to have a broken or painful implant removed but are still paying for the initial augmentation surgery and unable to afford corrective surgery.

Liposuction also carries potentially serious risks. Primary risks include infection, damage to skin, nerves, or vital organs, fat or blood clots (that can migrate to the lungs, leading to death), and excessive fluid loss that can lead to shock or death. In addition, the different techniques are associated with complications such as skin or deep tissue damage, lidocaine toxicity, and fluid accumulation in the lungs [5].
The long-term physical, emotional, and economic sequelae of many popular cosmetic surgeries, including implants and liposuction, are unknown. Despite the documented risks, the general public has an inflated sense of the benefits and a minimized sense of the risks of plastic surgery [6]. Teenagers are often oblivious to the well-documented long-term health consequences of smoking, tanning, and other risky behaviors, and are likely to pay even less attention to the risks of cosmetic surgery, making informed consent difficult.

In addition to the influence of persuasive and pervasive advertising and television makeover programs that stimulate demand, it is difficult for a physician to neutrally present both the risks and benefits of an elective procedure that he or she is simultaneously selling [7]. Requiring parental consent for patients under 18 does not ensure informed consent, since research is lacking on long-term risks for many cosmetic procedures.

Screening

One way to help ensure that teenagers are mature enough to make decisions about plastic surgery is to screen potential patients using psychological testing. In media interviews, plastic surgeons often describe careful interviews aimed at determining why the teen wants plastic surgery. Unrealistic expectations or having the surgery to please a boyfriend is considered inappropriate, but having surgery so that “I will feel better about myself” or “clothes will fit better” are considered reasonable responses. By the same token, teenagers who use drugs, drive while inebriated, and have unprotected sex may also make those decisions to please themselves, and not others, so that response alone is not sufficient evidence of a mature decision. Currently, there is no evidence that effective screening is widespread.

Teen Self-Consciousness and Plastic Surgery

Teens expect that plastic surgery will improve their self-confidence, but does it? There are no empirical studies examining the long-term benefits among adolescents. One study found that body-image satisfaction improved after cosmetic surgery, but so did

satisfaction among the control group, suggesting that improved body image may occur with increasing age, regardless of whether the patient undergoes plastic surgery [8]. In fact, a longitudinal study that followed adolescents from age 11 to 18 found body image satisfaction rates were highest at age 18 in both sexes and that the satisfaction of individual participants varied as a function of their age and developmental stage [9]. This indicates that many adolescents who are very dissatisfied with their appearance will feel more satisfied a few years later, whether or not they undergo surgery. The same study also found that the physical features with which participants were most dissatisfied reflected culturally determined stereotypes of idealized attributes emphasized in books, mass media, and advertisements.

Research indicating that breast augmentation patients are 4 times as likely to commit suicide compared to other plastic surgery patients [10] raises questions about the mental health of the women who choose implants and the psychological benefits of the surgery. Liposuction is also of particular concern because of its association with eating disorders. The average onset of body dysmorphic disorder (BDD), defined as "a preoccupation with an imagined or slight defect in appearance that leads to significant impairment in functioning," is 16 years of age [11]. However, since the goal of cosmetic surgery is to improve and transform appearance, it may be difficult to distinguish between this desire and a pathological preoccupation [12].

Who decides?

Will most plastic surgeons make an accurate and objective judgment about whether a teenage girl is an appropriate candidate for plastic surgery? If plastic surgeons are performing surgeries that many physicians and psychologists would question, should medical societies and ethicists provide more guidance than is currently being provided by plastic surgery associations?

In the ideal world, informed consent would enable teens and their parents to decide carefully what is best for them. However, in the absence of longitudinal research, it is impossible for physicians to warn patients, or their parents, about the risks of performing cosmetic surgery on bodies that have not reached maturation, the operative complications and long-term physical effects of these surgeries and the psychological implications of surgery on developing body image, or the extent to which distorted body image common among adolescence may result in the pursuit of plastic surgery.

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Op-Ed
Ethics of Cosmetic Plastic Surgery in Adolescents
by Michael A. Bermant, MD

Appearance and deformities are important to anyone who engages in social interaction. Teens as well as adults have valid cosmetic conditions that benefit from plastic surgery. Adolescent cosmetic surgery is not new, but the topic has come to the forefront as a result of recent media attention. The most common sources of information for teens about plastic surgery are magazines and television [1]. The quick fixes on television "reality" shows can establish unrealistic expectations and distort the facts about actual plastic surgery.

Teens are often uncomfortable with their evolving bodies. Distortions in body appearance can lower self-confidence and disrupt social acceptance. This can result in difficulty with school, aggression, or withdrawal. The cosmetic procedures teens desire most to alter their appearance in ways that improve their self-confidence are liposuction, rhinoplasty, and breast augmentation [1].

A major factor when considering an adolescent patient for plastic surgery is that the patient is still growing. The body itself is maturing, decision-making skills are evolving, and social skills are forming. Every analysis for potential surgery must weigh the following:

- Purpose for surgery: Is the proposed surgery realistic? Does the patient seem competent to make the decision to have surgery?
- Degree of deformity: Is the deformity noticeable? Are the patient's expectations for correction appropriate?
- Level of physical maturity: Will the patient grow out of the deformity?
- Social costs: Does the patient suffer socially because of the problem?
- The patient-parent decision: Are the parents supportive of the surgery? Are the parents pushing for the surgery against the patient's desires?
- Post-surgery patient attitude: Will the patient be able to adhere to a post-operative regimen?

To illustrate the application of these guidelines, I will discuss several common surgeries requested by adolescents and the factors important in each.

Rhinoplasty
Rhinoplasty (nose reshaping) [2] is among the most requested surgical procedures for teenagers and, if done early, can prevent years of emotional distress. For a teenager concerned with appearance, a large or deformed nose in the center of the face gathers

much attention. Rhinoplasty can be performed when the nose has completed most of its growth, which happens as early as 13 to 14 years in girls and about a year later in boys. When an unsightly nose is refined with cosmetic surgery, there can be a transformation in confidence, attitude, and demeanor.

For teenage nasal sculpture, one must evaluate the patient's purpose for surgery and ensure that the patient has realistic expectations. Enhancing the positives and subtracting the negative features are acceptable goals; trying to imitate a famous person's nose is not.

Gynecomastia: Male Chest Contouring Plastic Surgery

Gynecomastia, or female-sized breasts, is particularly distressing to males [3]. Protruding breasts can result in mockery, social avoidance, and maladaptive behavior. Although gynecomastia can occur at any age, adolescents are particularly susceptible during their hormone changes [4]. While most teenage gynecomastia resolves, that which has not resolved after 2 years typically will not. Many adolescents have stable gynecomastia problems; some have breasts that continue to grow. The problem affects each individual differently; a significant deformity can be subtle or massive in the patient's eyes. It takes very little breast tissue to make "puffy nipples" stick through a shirt or disturb a male chest contour.

Forcing a 13-year-old boy with C cup breasts to go to gym and play basketball shirtless can be cruel. The surgeon must weigh whether to perform surgery early and risk further growth or delay surgery and deal with the emotional problems due to large breasts. One must also balance the possible need for secondary surgery after further growth. I have treated many men, now independent and able to make their own decisions, who were angry that pediatricians kept saying their breasts would go away. In some of those cases, parents totally ignored the emotional stress of gynecomastia.

Female Breast Reduction

Some adolescent women suffer from massive breast size [5]. Macromastia can result in pain from weight, awkward momentum, shoulder grooving, and social distress [6]. An appropriate teenage breast reduction can result in an amazing transformation.

Making a teenager wait until her body further matures can be brutal. Early surgery, however, carries the risks both of further breast growth and a patient's decision about breast size that she regrets as an adult.

Otoplasty: Ear Cosmetic Plastic Surgery

Protruding or deformed ears can cause concerns for children and adolescents [7]. Some do not want to, or cannot, wear their hair long for camouflage. Otoplasty is an option to bring projecting ears closer to the head, balance elements of the ear, or rebuild deformed components [8].

The ear reaches almost adult size by the age of 5. Young children's cartilage is softer, resulting in an advantage for earlier plastic surgery. Firmer adult ear cartilage may need to be weakened during surgery, a potential distortion risk that can often be avoided in younger children. Projecting ears are a typical deformity often subject to much ridicule. External ear deformities are best treated before children start social interactions.

Inverted Nipples Cosmetic Surgery

Inverted nipples can be unattractive, causing distress for some adolescents [9]. A major factor in the decision to pursue this surgery is the patient's gender. Although duct-sparing procedures can help lesser deformities, some nipple inversion requires that the ducts be surgically divided for correction. Duct division can result in a woman's inability to breast-feed. Hence, for some women, this surgery may be better postponed until adulthood. On the other hand, for a male teenager with nipple inversion from adherent gynecomastia tissue, gland and ducts have no function. Release of this adherent tissue and the subsequent change in the patient's chest sculpture can have a major positive emotional impact for him.

Losing Weight and Plastic Surgery

Liposuction can be valuable for sculpting tissue [10]; it is not very useful for reducing weight. Removed fat cells are gone, but remaining fat cells can accumulate more fat. Teens therefore may better manage their weight loss by a change in habits, dieting, and exercise. Plastic surgery is better employed as a refinement tool.

In the maturing female teenager, body fat distribution is evolving. Many teens' body shape and habitus will change during the teenage years. A chubby teenager may grow in height and become a slim young adult. The degree of deformity must be balanced against advantages of waiting until the contour better defines itself.

Plastic Surgery after Massive Weight Loss

After a patient loses a large amount of weight, connective tissue fibers in the skin and fascia may be so stretched that folds of flesh remain [11]. Although younger skin tends to shrink better than older skin, redundant folds can remain around the stomach circling around the back, the chest and breast region, thighs, arms, and neck. Plastic surgeries such as a tummy tuck, body lift, thigh lift, arm lift, or facelift are options [12]. For an adolescent patient, the surgeon must balance the degree of deformity against further body growth filling in the loose skin. The patient's level of emotional distress and the concern for regaining of the weight must also be addressed directly and honestly.

Navel Cosmetic Surgery

The present popularity of the bare midriff style of dress exposes the belly button, a focal point of the abdomen [13]. For a teenager, peer pressure and clothing choice can lead to stress over the appearance of the navel. The "outie" shape of the navel bothers many patients; it is difficult to adorn an "outie" with navel jewelry. Belly button umbilicoplasty can easily convert an "outie" to "innie" navel. Unlike nasal, ear, or breast problems, camouflage by clothing is an option for this condition.

The Parents

Although parents have the legal responsibility for their adolescents, the impetus for surgery needs to come from the patient. In elective cosmetic surgery, it should be the patient who is bothered by the problem and is looking for a solution, not the parents.

Conclusion

The deformity, physical and emotional maturity, and desired outcome for each

adolescent patient must be carefully evaluated before any decisions are made. Additional consultations and long discussions before plastic surgery are often merited. Sometimes, however, the real question is: is it ethical *not* to operate on an adolescent patient?

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Medical Humanities
Adolescence and Gender Identity
by Allison Grady

The memoir *She's Not There* by Jennifer Finney Boylan explores the little-known and often misunderstood world of transgenderism. In Boylan's book and for the purposes of this discussion, the term trangendered describes individuals with a range of gender issues [1]. What they share is some degree of discomfort with their physically assigned sex. *She's Not There* allows lay people to better understand the challenges and stigmas attached to this condition, and, for doctors in particular, this story offers both clinical information and personal narration about an illness that many times is first recognized during adolescence. *She's Not There* sensitively illuminates the human side of an uncomfortable topic in an approachable and entertaining manner.

During the turbulent formative period known as adolescence, many young people struggle with their identity. The struggle entails questions about personality, sexuality, and, sometimes, gender. Because of our society's rigid views of gender roles and behaviors assigned to males and females, young people can find it difficult to voice their doubts and frustrations about a topic so many take for granted. The experience Boylan describes can help doctors who work with adolescents to understand that asking about someone's gender identity is different from asking about sex and sexual activity. By knowing what types of questions to ask and separating gender from a discussion about sexual conduct, doctors can begin a productive conversation. Boylan writes:

> My conviction, by the way, had nothing to do with a desire to be feminine, but it had everything to do with being female…It certainly had nothing to do with whether I was attracted to girls or boys…being gay or lesbian is about sexual orientation. Being transgendered is about identity. What it's emphatically not is a "lifestyle," any more than being male or female is a lifestyle [2].

Boylan's story underscores the idea that transgenderism is not about sexuality nor is it about "choice." For many who suffer with what the Diagnostic and Statistical Manual of the American Psychiatry Association calls "gender identity disorder," being transgendered is an unfortunate reality of life [3]. It is important for doctors to provide a place that is safe and sensitive to privacy and discretion. They must be able to speak frankly and honestly with patients without injecting their own prejudices. Primary care physicians can take an active part in the diagnostic phase by making referrals to mental health professionals who can further explore gender questions. Typically, therapists will ask about "sexuality, marginality, culture, and archetype, about the difference between reality and fantasy…medical history, history of abuse or neglect" [4]. Because

of the unique nature of the condition, a referral should be made to a therapist who is either a specialist or has relevant experience with the transgendered population. But primary care physicians who are not particularly familiar with treatment for transgenderism can still provide support, trust, and respect for confidentiality when working with teenagers and younger patients, especially.

Transgenderism is about more than just feelings. Some individuals decide that living as one gender, while feeling much more like a member of the other is no longer tenable, and they seek surgical reassignment. Because this is a medical process, doctors are necessarily involved and, depending on the confidence level of the person seeking gender reassignment and his or her family, physical changes can be embarked on during adolescence. *She's Not There* discusses the medical process of going from being physically male to being physically female (M2F). Boylan noted that the most important clinical document used when proceeding with gender reassignment is the Benjamin's Standards of Care (SOC). The SOC outlines the clinical roles and obligations of doctors and mental health professionals working with transgendered persons. One section of the SOC addresses the ethically and clinically permissible actions for adolescents [5]. To be eligible for gender reassignment surgery a person generally must enroll in therapy, begin to live as a member of the desired sex, be on a continuous hormone regimen for a minimum of 12 months, then live full time as the desired sex for a minimum of 1 year, and receive clearance from at least 2 medical specialists [5]. This process takes several years, and, because of the numerous physical and psychosocial changes that occur, the participation of a doctor is critical throughout.

The SOC allows for the process to begin as early as age 16, but, given the identity issues inherent in this phase of life, the adolescent must be in the care of both a dependable therapist and a doctor who is clear in his or her discussions with the young person, competent on the subject, and able to be in constant communication with the others on the care team. When adolescents both recognize and articulate their desire to begin reassignment, the doctor must respond and work in conjunction with family, other doctors, schools, and all major actors in the "patient's" life. (At this point, the adolescent, though not sick, is being treated with hormones and, perhaps, other drugs and is anticipating surgery. Hence, the designation "patient.") While the most dramatic portions of transition cannot occur until age 18, the doctor must continue to follow younger patients to impress on them the gravity of transition and assure them that, any time prior to surgery, treatment can cease. No matter what the age of the gender reassignment candidate, the doctor should work with him or her and family members, explaining the physical and psychological changes that will occur as transition progresses. With adolescents in particular, physicians must be responsive to the fact that relationships are naturally in flux; many friends and even family are unable to accept the artificially created hormonal and physical changes, and this can cause greater interpersonal instability. Boylan, who actually postponed reassignment surgery until her mid-40s, uses much of *She's Not There* to describe the changing relationships with her wife and with her best friend—who is a man. Just prior to her surgery, Boylan's wife shares her opinion about the reassignment:

> All I've ever said…was Wait, please, stop, slow down, and to that you've responded with all sorts of words about your suffering, about what you've been through, about how you don't have any choice, about how this is mostly a medical issue…You're going where you feel like you need to go. For me, I'm standing here watching [6].

She's Not There demonstrates how radically relationships, world views, and expected "life paths" change for someone who is transgendered and chooses to confront the impulses. For those in high school who may be living as the "opposite" sex, doctors can help by looking out for signs of abuse or bullying, depression, problems at home, slipping of school work or avoidance of classes, and questions or hesitancy surrounding dating. For adolescents embarked on the process of change, mental health experts must work with school officials to make arrangements for locker room and bathroom use, determine how the school will address the student (eg, often a person living as a member of the opposite sex will adopt a new first name), and train staff in a basic understanding of transgenderism and the stereotypes that surround this condition. It is currently estimated that there are 40 000 transgendered people who have undergone male-to-female surgery, making this more common than cleft palate and multiple sclerosis [7].

She's Not There is an untraditional coming-of-age story; it describes one man's journey into womanhood beginning in adolescence. It touches on major themes and explains some misconceptions in an eloquent but still very personal way. Boylan's experience will not act as a mirror for all, but does provide insight and intrigue into a world that is shrouded in privacy, secrecy, and often, shame.

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