his case presentation which is synthesized from the authors’ clinical experiences, discusses a health maintenance visit for a 16-year-old boy. On routine screening, his pediatrician identifies that he is using marijuana and at times driving after smoking. Two expert clinicians discuss the challenges of managing adolescents and when and how to risk the therapeutic relationship by breaking confidentiality.

CLINICAL CASE

A 16-year-old boy presents for a health maintenance visit. He used to be followed by one of your practice colleagues, so is known to your office but a new patient for you. You conduct your patient interview using the Home, Education/Employment, Activities, Drugs, Sexuality, Suicide/Depression (HEADSS) format so that a systematic and detailed assessment of his activities includes asking him whether he has ever drank alcohol, smoked marijuana, or used another substance (illicit drug, over the counter product, prescription medication, or inhalant) to get high. He tells you that he has drank alcohol and smoked marijuana. He has never used other substances to get high. You administer the Car, Relax, Alone, Forget, Family/Friends, Trouble (CRAFFT) questions,1,2 and his score is 2—he has driven after smoking marijuana, and he has smoked marijuana alone.

Given his positive CRAFFT screen, you do a brief assessment. When you ask about his marijuana and alcohol history, he tells you that he has drank alcohol on 3 occasions—approximately 5 drinks each time. He has never been sick from drinking alcohol, had an alcohol-induced blackout, or physically passed out. He has been using marijuana 1 to 2 times per week for the past 2 years. He has never been a daily marijuana or tobacco smoker. He does quit marijuana use for 3 months during basketball season, because he believes that his exercise endurance is better when he is not smoking. He does not believe he has any other troubles related to his marijuana use. His grades are good, he has never been suspended or in a physical fight. He says that he frequently drives after smoking and adds that he believes that he is a much better driver because he is “much more focused” after smoking. He denies trouble associated with marijuana use, and says that his parents do not know that he smokes. You review with him your version of the “Contract for Life” through which you request that he sign a contract with you agreeing that he will never drive after smoking marijuana. You request the patient schedule a follow-up appointment with you in 1 week, and he agrees.

1ST SCHEDULED FOLLOW-UP

The patient does not return for his scheduled follow-up appointment. You are worried about the possibility that he is driving while intoxicated, and you ask your staff to call him on his cell phone to reschedule. On the seventh phone call the patient answers the phone and reschedules his appointment for 1 week later.

2ND SCHEDULED FOLLOW-UP

The patient does not return for the second scheduled follow-up appointment. Given your concerns, you decide that he is posing an acute safety risk, and decide to break confidentiality. You call the patient’s parents and ask them to come for a follow-up appointment with their son. The mother is extremely concerned on the phone; you tell her, “your son had a positive screen and I need to follow-up with both him and you. I would prefer to speak with you in person. I will transfer your call to the front desk staff so that they can schedule you an appointment this week.”

3RD SCHEDULED FOLLOW-UP

Two days later, the patient presents with his mother. You first speak alone with him. He is angry and feels that his confidentiality has been violated. He further says that you have no right to speak with his parents, and he has no intention of quitting marijuana use though he does agree to try to stop driving after smoking. You remind him that the limit of confidentiality is safety, and that by refusing to participate in follow-up and ensure his contract not to drive after smoking marijuana he has crossed a safety limit. You then tell him that you will need to speak with his mother, and would like his help in deciding what to tell her. He sits quietly, without saying a word. After several moments of silence, you suggest the following, “As you know your son...
came for a physical examination a few weeks ago, and he was very honest in answering questions with me. He told me that he has been smoking marijuana. After assessing him, I don’t think that he has a diagnosis of marijuana dependence, or an addiction, but I do think that his smoking is risky. He has agreed to sign a contract that promises he will never drive after he has used marijuana, or ride with a driver who is intoxicated, and that is an extremely important first step. I would also like him to meet a couple of times with the social worker in our office to discuss this further.” You ask him if he would like any changes in the way the information is presented, and whether he would like to tell his mother or you should do it. He asks you to tell her.

The patient’s mother comes in the room and you share the information just as you had agreed. She becomes angry and insists that she will not tolerate her son smoking marijuana. You point out that her son was honest in his conversations with you, that he is willing to agree never to drive while intoxicated, and to meet with the social worker in your practice to discuss this further. You recommend that the boy’s mother and father schedule their own appointment with the social worker. You further suggest that the parents and son do not discuss drug use for the next 48 hours, until everyone has had a chance to cool down, and they both agree. Mother and son both look angry as they leave your office. On the way out, the mother turns to you and thanks you for letting her know that her son had been putting himself in danger.

DR. KNIGHT

This case illustrates how difficult it can be to schedule and complete follow-up appointments with adolescent patients who have screened positive for substance abuse. While substance abuse screening is recommended as a standard part of the yearly health maintenance visit.3,4 This recommendation is made based on the assumption that the majority of adolescents who have not used alcohol or other drugs will benefit from positive reinforcement, those who have begun to use substances but are “low risk” will benefit from quick and inexpensive office-based interventions, and adolescents found to have substance use disorders will benefit from early referral. However, to our knowledge, no cost:benefit analysis has ever been published. Furthermore, substance use is not a topic likely to be high on the list of the adolescent patient’s priorities. Imagine the surprise and consternation of the typical 16-year-old, who may be more concerned about his acne or a sore knee, when the doctor tells him he has screened positive for substance abuse and needs to come for a follow-up visit to discuss it further. In one of our early studies on validity of the CRAFFT screen,5 we implemented a safety protocol as part of the plan to protect adolescent participants in research. The plan called for a referral to the clinic social worker for any participant who was found to meet diagnostic criteria for substance abuse or dependence based on a structured psychiatric diagnostic interview conducted by a research assistant. Seventy-five participants were found to have an abuse or dependence diagnosis and all were given an appointment with the clinic social worker. None of the adolescents kept their appointment.

Avoidance is just one of several defense mechanisms that may be employed by adolescents who have a substance-related disorder. Others may be denial (“Oh I really didn’t mean that I smoke marijuana by myself. That just happened one time and I was on my way to a party with lots of other people”), minimization (“Smoking marijuana actually improves my driving—I drive slower and I’m more careful”), or normalization (“Everyone in my school smokes pot”), among others. The problem with avoidance, when it negatively impacts adherence with follow-up appointments, is that it places the adolescent at increased risk. We typically inform adolescent patients that we will keep their answers to questions about substance use confidential, unless there is a risk to their own safety or the safety of someone else. Although there are no absolute rules on exactly what comprises a safety risk, few providers would consider occasional use of alcohol or marijuana rising to the level of a safety risk that necessitates informing parents.

However, failure to keep follow-up appointments that are required to ascertain the severity of use or implement counseling does pose a serious risk to safety. In the case presented here, the provider tries twice to schedule a follow-up appointment, and decides to inform the patient’s parents after the second failure of the patient to keep the appointment. One strategy that might have been used would be to inform the patient that failure to make or keep appointments would in fact force the doctor’s hand into informing parents, because of the importance of the follow-up visit. Although this tactic is undoubtedly coercive, it might have succeeded in demonstrating to the adolescent just how seriously the doctor views the problem. In any case, informing parents about substance use often increases the likelihood that counseling or treatment will be effective. The downside is potential damage to the doctor-patient relationship. In the case presented, the doctor correctly tries to mitigate the loss of trust by discussing with the adolescent exactly what information will be given to the parent.

DR. WILLIAMS

This case report points up several interesting issues about confidentiality and informed consent that are pertinent to those delivering health services to adolescent patients. Protecting the privacy and confidentiality of adolescents’ health care information is an essential determinant of whether adolescents will access available care, where they choose to seek care, and whether an effective doctor-patient rapport can be developed and maintained during the provision of medical services to adolescent patients.6,7 It has been shown that adolescents delaying or forgoing health care because of concerns that their care will not remain confidential are generally teens who already have health issues, and those health problems are more likely to be ones for which evidence-based management is effective.8

Health care professional organizations guiding best practices in adolescent and young adult medical care, including the American Medical Association, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians,
and the Society for Adolescent Medicine, have established position papers and policy endorsements supporting confidentiality and informed consent in this age group and addressing the medical, legal, and ethical ramifications that face patients and clinicians alike.9,10 The term confidentiality is defined as “an agreement between patient and provider that information discussed during or after the encounter will not be shared with other parties without the explicit permission of the patient.” Informed consent means “an individual can understand the diagnosis, risks and benefits of a proposed treatment, alternative procedures and treatments and their associated risks, and the consequences of not undergoing the proposed procedure and treatment. The individual must also be able to decide voluntarily whether to proceed with the physician’s recommendation.”11 Confidentiality and informed consent are separate but closely related concepts.

Until approximately the last 30 years, minor children in United States were still considered parental property and not able to enter contracts, including giving consent for medical care. As research has afforded greater understanding about normal cognitive development and the high prevalence of risk-taking behavior during adolescence, these factors have combined into a driving force underlying an evolution in the legal rights of this age group. All states now have laws allowing minors to consent for certain health services without parental notification, most for emergencies, sexually transmitted infection treatment, contraception, pregnancy, mental health care, and alcohol or other substance abuse treatment. States’ laws differ significantly regarding which services for which adolescents have the right to consent still require parental notification. The high amount of state-to-state variability makes it essential that practitioners stay fully informed about the laws governing the states where they practice.12–14

Crucial to the trust relationship between patient and provider, confidentiality provisions should be introduced and defined as a high priority during a patient’s initial visit, and reiterated and clarified during subsequent appointments to achieve understanding by the patient and parent(s) about confidentiality, what it does and does not provide, and what are the limits to upholding or breaching it. Some physicians do not consider confidentiality conditional, as shown by Ford who found that 64% of the 53% of physicians discussing confidentiality with their adolescent patients assured unconditional confidentiality.15 Other studies have reported that the provision of confidential care varies with respect to the type of problem addressed. Of a group of pediatricians and family practitioners, 75% supported confidential care for adolescents in general, but only 54% kept drug use confidential.16 The patient in this case was an established patient in the practice where he sought health maintenance care, but he saw a new provider for this visit. It is likely that this provider reiterated with him the tenets of confidentiality upheld by practitioner colleagues in that office, because the patient had a remarkably open discussion about his substance use and expectations, which were later revealed, about what the practitioner would keep confidential.

A well-established standard of adolescent medicine practice, demonstrated by this case, is to conduct a detailed patient interview to obtain a comprehensive history usually by utilizing a framework, such as the HEADSS interview format, to facilitate discussion of the principle influences and aspects of the adolescent patient’s life, including topics that are potentially sensitive or posing health risks, such as the use of alcohol, tobacco, and other drugs.1 The physician and teen must review confidentiality concepts before this conversation can take place, so the following must be verbalized, “Everything we discuss here today will remain ‘confidential’; in other words, will stay between you and me, except when your or another person’s safety is in danger. If there is a real risk of harm to yourself or others, and it is determined that confidentiality between us must be broken, we will discuss ahead of time what details you and I must share with your parent(s) and what will stay confidential.”

What limits confidentiality, justifying the physician to breach this trust, is generally the need to prevent imminent harm and protect someone’s safety, such as when the risk of suicide or homicide arises, and in regard to substance abuse, any indication for acute hospitalization, medical supervision of withdrawal or detoxification, or residential treatment. Breaching confidentiality also comes into play when meeting the legal obligations for reporting suspected sexual or physical abuse or sexually transmitted infections. Situations such as a suicide threat clearly warrant breaking confidentiality, but other situations, including many issues related to substance use, are not so clear, leaving the physician to make an individual determination, such as in this case. No studies have shown whether providing care and unconditional confidentiality related to adolescent substance use results in better outcomes than does care when confidentiality can be breached.

After employing the tenets of confidentiality, the clinician introduced the patient to the Contract for Life, and engaged the patient in the informed consent process needed for him to sign the contract as a means of addressing the principle threat he was experiencing from his drug use—driving after having used marijuana. Because the patient clearly agreed to stop this specific risky activity, yet did not return for office follow-up, the physician had no verification that the patient’s driving under the influence of marijuana had actually stopped. To this pediatrician, driving after marijuana use was sufficient grounds to breach confidentiality, based on the imminent danger that the patient posed to himself and, it could be argued, to others. The patient, on the other hand, was angry about this breach of confidentiality, and needed to be reminded that risks to safety are legitimate determinants of confidentiality limits.

As part of the anticipatory guidance given during a health maintenance visit, pediatricians should provide important risk-reduction information to patients engaging in risky behaviors, such as substance use, particularly when negative consequences of the behavior have not yet occurred. When the risky behavior has already resulted in problems, the physician should respond with at least brief intervention modalities, depending on the extent of the problem. The Contract for Life was used with this patient as a type of brief
intervention. It was meant to represent graphically the risk about which the pediatrician had the most concerns, but also to serve as a motivational tool for the patient. The patient denied trouble from his marijuana use and was certain that he was in control of it. The Contract for Life is one means of acknowledging the patient’s possible “control,” while having the potential to demonstrate to the patient that his beliefs represent fantasy and not reality, thereby motivating change. Some physicians use the Contract for Life not only as a written pact between the doctor and patient, but also as a tool to facilitate discussion between the patient and their parents, echoing the Contract’s original intent.

The Contract for Life (http://www.sadd.org/contract.htm) is a prevention concept and communication tool devised by the Students Against Driving Drunk (SADD) initiative, which was found in 1981. In 1997, this initiative instituted an expanded mission and name change to the Students Against Destructive Decisions, and continues to serve as a peer-based education and prevention organization, addressing substance abuse and other destructive behaviors and attitudes, such as underage drinking, impaired driving, violence, and suicide. SADD believes that the pressures experienced by teens and young adults can be too great to experience alone, and effective parent-child communication is critically important to making healthy decisions.

One lingering question about supporting adolescents’ right to access confidential health services is whether confidentiality protections for adolescents are in conflict with parents’ interests or detrimental to parent-teen communication. Research results have been very consistent in showing that even when confidential health services are available, such as in family planning clinics, parents of at least half of the adolescents are aware of them using these services.17 Teen participation in confidential health services and informed consent decisions is not mutually exclusive of the desirability of parental involvement for the patient or for the physician. The Society for Adolescent Medicine’s position statement on the delivery of confidential health services to adolescents specifically enumerates that “health care professionals should support effective communication between adolescents and their parents or other caretakers.”10 Participation of parents in the health care of their adolescents should usually be encouraged, but should not be mandated.” There are times when parental involvement poses a significant risk to the teen, which is also important for the health care provider to recognize. Lehrer et al8 found that the prevalence of the risk factor “unsatisfactory parental communication” was significantly higher among girls who cited confidentiality concerns as a reason for not seeking health care than among those who did not.

Physicians providing confidential services to teens have found that their growing doctor-patient relationship offers many opportunities to encourage parent-teen rapport in a way that addresses the teen’s particular needs while not betraying their trust. In substance abuse treatment, an important determinant of treatment success is the extent to which the parents are involved in their child’s treatment and recovery processes. In the case presented, the clinician informs the patient’s parents about their son’s marijuana use, but they are also made aware of his honesty and stated willingness to change a significant health risk behavior. The conversation engaged parents and teen in the intervention and treatment plan together and gave them guidelines for a continuing rapport despite the disturbing revelation of substance use. The physician, patient, and family have embarked on an important challenge now facing them—to maintain this rather new but supportive working relationship through the adolescent patient’s successful recovery from substance use.

**SUMMARY**

Two expert clinicians discuss the management of an adolescent patient who was found to have high-risk use of marijuana during a routine screen. The ability of universal screening to find patients who are engaging in risky behaviors presents an enormous opportunity as an adolescent such as the one presented here is unlikely to be invited to discuss his substance use in other settings, unless he experiences a consequence associated with his use. In this particular case, the consequences of a car accident could be devastating. However, screening and case finding is not enough. Once a screen is positive the clinician must be able to implement an effective intervention to actually reduce risk. Many types of brief interventions have been proven effective, and in this case contracting not to drive after using marijuana and follow-up seems to be a reasonable approach. Unfortunately, experience has demonstrated that in the case of risks such as drug and alcohol use, follow-up can be difficult to assure. In this and similar cases, the clinician must weigh the risks of breaking confidentiality—including damaging a therapeutic relationship and potentially encouraging this patient to withhold information from his physicians in the future—with the benefits—reducing his risk of driving while intoxicated and engaging him in further treatment. This is always a difficult decision; the expert comments help by presenting the historical context, relevant research findings, and professional guidelines.

**REFERENCES**


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