# Virtual Mentor
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**ETHICS CASES**
## Confidential Mental Health Treatment for Adolescents
Commentary by Pablo Rodriguez del Pozo, MD, JD, PhD

Dylan is a bright 16-year-old student who has depression, which he discussed during his last appointment with his longtime family physician, Dr. Emory. Dylan's parents divorced a year and a half ago and Dylan has been struggling to adapt to the change in living situation.

During his annual sports physical, Dylan reveals that he has started having thoughts of cutting himself. He feels that his depression has gotten worse and admits to "checking out web sites" about cutting or otherwise harming himself. When Dr. Emory questions him further, Dylan just shrugs and seems noncommittal about what he means by hurting himself. He even says that he "won't actually do it."

Dylan wants a prescription for an antidepressant but begs Dr. Emory not to tell his mother, who is in the waiting room. Dr. Emory counsels Dylan that depression and thoughts of cutting himself are serious issues and recommends involving a therapist and the support of his parents. Dylan is very much against this idea.

Dr. Emory believes that a low-dose antidepressant will help Dylan but is uncomfortable with writing the prescription without, at the very least, frequent follow-ups to monitor Dylan's depression and thoughts of self-injury. Yet Dylan is reluctant to agree to another appointment in two weeks. "I can't tell my mom I have to come back again so soon!"

As their family physician, Dr. Emory knows that Dylan's parents are divorced and share custody of Dylan and his younger sister. He also knows that Dylan is close to his grandma across town. He asks Dylan if he would be willing to involve his grandma, as someone to support him and drive him to appointments. Dylan seems more open to the idea, but still would rather just start on an antidepressant without telling anyone.

Dr. Emory has a good rapport with Dylan but thinks he probably needs more help and support than he can offer, especially since Dylan is unlikely to follow up on his own.

**Commentary**
Complex forces pulling in opposing directions define this case involving a teenager visited by thoughts of cutting himself. The patient, Dylan, is a young man in the throes of adolescence and divorce—and, perhaps, depression. The physician, Dr. Emory, is torn and may not be entirely comfortable with whatever decision he makes.

To begin with what we know and don't know: Dylan is a bright teenager whose parents divorced 18 months ago. He is depressed and has had self-destructive thoughts. The vignette does not provide detailed information about, or a clear timeline of, Dylan's symptoms of depression. During a previous visit, Dylan had mentioned he was feeling blue. But Dr. Emory knows that the teenager is struggling to come to grips with his new family dynamics. It is unsurprising that Dylan is not cheerful. In this most recent visit, Dylan asks to be put on antidepressants and mentions that he wants to cut himself—though he clarifies he's unlikely to actually do it.

**Dr. Emory's Dilemma**
Teenage depression is an elusive diagnosis: adolescence is a phase of life marked by mood swings that can last from hours to days to months. Dylan's clinical condition is far from clear-cut, and in my view Dr. Emory's first dilemma is not ethical but rather clinical. Dr. Emory can't medically pronounce Dylan to be depressed based solely on the feelings that the young man expresses on two occasions. And yet he can't rule out a diagnosis of depression, either.

Dr. Emory thus faces a clinical dilemma which presents a second, now moral dilemma.

Underage patients enjoy in most states in the U.S. an *ad hoc* legal capacity to consent by themselves to certain medical services, such as those related to reproductive health, substance abuse and—as in Dylan's case—outpatient mental health. The purpose of this exception to the rule of capacity is to protect the confidentiality of patient information. Otherwise, the fear of disclosure would prompt minors to forgo health care services, risking their health and sometimes that of others. Dylan can consent to outpatient mental health care and has the right to do so confidentially [1, 2].

However, this *ad hoc* capacity and the confidentiality attached to it cannot go beyond the reason they are granted in the first place, namely to protect the health of minors. State legislation thus authorizes doctors to disclose information if confidentiality poses a risk to the health of the minor or others.

That means that if Dr. Emory hastily decides that Dylan suffers from depression and is at risk of suicide, and Dylan is actually neither, the doctor would be breaking his duty of confidentiality unjustifiably, since this diagnosis (most particularly if

followed by treatment with antidepressants) would almost certainly entail his informing Dylan's parents. Dr. Emory knows that premature disclosure would destroy Dylan's trust in him and make Dylan even more resentful of the adult world at a time when he's in particular need of adults to confide in.

But if Dr. Emory does not pronounce Dylan depressed and suicidal and Dylan turns out to be both, he would be preserving confidentiality at the unjustifiable price of putting his young patient at risk.

Dr. Emory must not fail Dylan in either way. The clinical dilemma poses an ethical dilemma—yet another reminder that clinical judgment and ethical judgment are inseparably interwoven in the doctor's office [3]. And Dr. Emory needs to make a decision now, while Dylan is sitting in his office and his unsuspecting mother is waiting outside.

The goals of Dr. Emory's intervention at this point should be to arrive at a precise diagnosis by referring Dylan to a specialist, who may start the teenager on counseling and psychotherapy. Time is critical here, but Dr. Emory has the chance to buy additional time by combining an appealing plan with a gentle push.

**Adult Supervision**

This is where Grandma comes in. Dylan is open to the idea of involving his grandmother, with whom he has a close relationship. Involving Grandma seems like a good option for Dylan, but is it legal to involve her instead of his parents?

Given the outpatient mental health nature of the services required, Dylan has the right to conceal his clinical information from his parents. The right to exclude everyone implies, at the same time, that Dylan has the right to have that information selectively disclosed to a trusted adult, in this case his grandmother. Grandma would not become, though, Dylan's representative *in loco parentis*. She would simply be someone with whom Dylan has decided to share otherwise confidential medical information. Involving Grandma does not imply that Dylan waives his right to consent or to confidentiality, and he should be made aware of this.

His grandmother will not only drive Dylan to appointments for further evaluation and perhaps psychotherapy sessions, but she also will be in a position to monitor his progress, help with compliance, and be the friendly, protective listener that Dylan's situation seems to cry out for. In addition, she may be able to help Dylan gauge how much information his parents will receive. She can be a big help to Dr. Emory—and Dylan—in deciding if and when the parents need to get involved.

Now for the issue of antidepressants. Dylan is requesting that he be started on antidepressants without letting anyone know. Dr. Emory has here the chance to turn Dylan's request into a gentle nudge towards the plan he's proposing.

Antidepressants hardly seem to be an option at this point. First and foremost, Dylan's diagnosis is still not clear. Even if it were, antidepressants "may increase suicidal thoughts or actions in some children, teenagers, and young adults when the medicine is first started," the FDA warns [4]. Dr. Emory should educate Dylan about the indications and risks of antidepressants. These drugs call not only for medical follow-up, but essentially for family awareness and close monitoring—which Dylan has ruled out. Dylan should understand that nondrug treatments are probably safer and more effective [5, 6] with the added benefit that they require no disclosure.

This is one of those instances where doctors have the duty to use their power for the benefit of the patient [7]. Dr. Emory is in the position to stress to Dylan that that if he were started on antidepressants now, he would need to involve his parents. After proper evaluation and waiting to see whether Grandma's support and monitoring seem strong, Dr. Emory could consider antidepressants without disclosure. However, Dr. Emory would do well to work together with Dylan and his grandmother to bring his parents on board before others—insurers or social networking or a school official—do it for them.

**Maintaining Confidentiality**

There is always the strong possibility that the insurance company will tip off Dylan's parents. It is safe to assume that Dylan is covered by his parents' health insurance, and they might at some point receive information revealing Dylan's medical activities.

Under HIPAA regulations, Dylan can request that all communications to him from Dr. Emory's office and from the health plan are made confidentially by e-mail or a phone that is not shared with his parents. However, laws and regulations on this point are open to interpretation. In addition, billing and administrative information sent by the insurer is likely to leave Dylan in the open. On the other hand, information regulated by the Family Educational Rights and Privacy Act (FERPA) is exempt from HIPAA protection. This means that if medical information about Dylan's mental care reaches his school for any reason, Dylan's parents will have the right to access it as they have the right to access their son's grades [8].

Last but not least, Dylan may undermine his own confidentiality. Adolescents and young adults e-mail, text, and Tweet themselves to thumb tenosynovitis [9] and addictively use Facebook [10]. It would surprise no one if information shared on social networking web sites somehow reached Dylan's parents.

**Concluding Remarks**

Dylan's case illustrates the ethical component inherent in clinical judgment. Of course the clinical facts must be clearly understood to make sound clinical judgment; technical competence is thus the first virtue of a good doctor. But when a situation is clinically problematic, it is often morally problematic as a corollary. Dr. Emory must determine what is best for his patient in the broadest sense.

Determining the clinical facts may be constrained by nonclinical aspects of the case. And the final goals of medical care [11] are not limited to instituting a treatment, but also encompass helping put in place a context that will enable it to work. Clinical practice does not happen *in vitro.*

Dylan's case also exposes how patients frequently have unrealistic expectations about the efficacy of medications and a complete ignorance of their risks. Doctors need to educate their patients on those benefits and risks.

The story affords us the opportunity to think about the limitations of the principles of autonomy and self determination in the case of minors. The last 30 years in medical ethics have been marked by the rise of those principles. In the case of minors, doctors are morally obliged to use their authority. However, such use may backfire if it is not applied in conjunction with educating young patients of the risks and benefits of the options.

Autonomy and confidentiality are granted to the underaged for the sole purpose of protecting their health but cannot be invoked when doing so would compromise that very specific purpose. It is a doctor's duty to draw the line, the heaviest and most delicate task Dr. Emory has on his shoulders.

The case, finally, reminds us that in a hyperconnected world, confidentiality may prove short-lived. And if confidentiality can't be guaranteed, protecting the health of adolescents may become an increasingly difficult enterprise.

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