

Virtual Mentor

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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The parents explained that Adam, previously a cheerful and garrulous boy, had become more withdrawn and sullen the past few months.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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