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PACE LAW REVIEW

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Health Law Symposium Speech

Overcoming Barriers to Health Services for Adolescents*

Wallace R. Jenkins, Jr.**

When I was told about this Symposium I was very happy to participate because adolescent medicine is my life. I am a pediatrician by training, but received fellowship training in adolescent medicine. I am blessed to have a private practice, a hospital-based practice, as well as clinic practices in affiliation with New York Medical College. Consequently, I work at St. Vincent's, St. Agnes, and Our Lady of Mercy Hospital. I have also worked in the emergency room and in the clinic setting at Lincoln Hospital in the South Bronx. There it is quite a different situation.

* This transciption was adopted from a speech given at the 1998 Health Law Symposium, *Children at Risk: Legal and Policy Barriers to Access to Health Care and A Healthy Environment for the Nation's Children* at Pace University School of Law on April 23, 1998.

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I want to do something that is almost impossible, and that is to give you a quick, basic understanding of adolescents and the problems that they face, especially in seeking adequate healthcare. There are physical, financial, emotional, and developmental barriers that adolescents have to overcome in order to access healthcare. The adolescent is a complex individual. I want to help you understand the psyche and the reasoning processes of the various stages of adolescent development.

The early adolescents are junior high school students, eleven, twelve, or thirteen years old. They are very concrete thinkers.[1] Immediate gratification is a part of their life. They have very little future orientation. Peers in their age group influence them more than members of their family.[2] The middle adolescents are fourteen, fifteen, or sixteen years old and now have some abstract reasoning and greater future orientation.[3] Some intimate contact has developed in this age group.[4] They start to think about life after eighteen, which is an eternity to them. They tend to be very fatalistic and dogmatic in their approach to life.[5] Finally, the late adolescent is basically an adult person.[6]

There are a few tidbits I would like to share with you. First and foremost, approximately one million pregnancies occur annually in the adolescent population.[7] These pregnancies occur between the ages of twelve to seventeen in the United States.[8] Further, almost eighty-five percent of all the pregnancies are unplanned.[9] Kids just do not get it. They do not think ahead. They act very impulsively, regardless of their education, standing, and socioeconomic status. A lot of these adolescent girls do not use contraception. Ninety percent of adolescent girls who do not use contraception will conceive.[10] As for activities and

1. *See* Donald P. Orr, *Helping Adolescents Toward Adulthood,* CONTEMPORARY PEDIATRICS, May 1998, at 65.
2. *See id.* at 59.
3. *See id.*
4. *See id.*
5. *See id.* at 66.
6. *See* Orr, *supra* note 1, at 59-60.
7. *See The Contraception Report,* PATIENT UPDATE (American Academy of Obstetrics and Gynecology), vol. VI, No. 3.
8. *See id.*
9. *See id.*
10. *See id.*

extracurricular pursuits, adolescents listen to an average of eighteen and one half-hours of music every week.[11] For those of you who do not know what they are listening to, I have a homework assignment for you: please go home and watch one half-hour of VH-1, MTV, or BET at seven o'clock, prime time. You will see naked bodies, drug use, violence, and unspeakable innuendo. Adolescents watch an average of twenty-four hours of television per week.[12] In 1998, the television in the American household was turned on an average of seven hours a day.[13] What are they watching? They are not watching PBS or the Discovery Channel. They are watching HBO, Showtime, Cinemax, The Movie Channel, and Playboy. Yes, they are watching Playboy. They have broken the "code" that is supposed to prevent them from accessing certain channels, and while you are at work, school, or studying, they are at home and they are unsupervised. If they are not listening to music or watching television, then they might be on the computer, using the Internet, with unlimited access to the sordid minds of many people in this world.

Ninety-four percent of all of the sexual encounters that take place on novellas or soap operas are between unmarried people.[14] I do not necessarily mean traditional couples. I mean people, partners. They could be heterosexual, or homosexual. This is what they are exposed to and you have to wonder what types of information they are getting and where they are getting it. How much of a role does the school play in this? Drug use is on the rise.[15] Marijuana has come back en vogue and heroin is being used again.[16] Pregnancy is also on the rise.[17] Some of the influences are helpful, some are harmful, but you have to

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11. *See id.*

12. *See The Contraception Report,* PATIENT UPDATE (American Academy of Obsterics and Gynecolgy), vol. VI, No. 3.

13. *See id.*

14. *See* Adolescent Sexuality and the Media, Center for Population Options, 1012 14th Street, N.W. Suite 1200, Washington, D.C. 20005 (citing B.S. Greenberg, R. Abelmabn and K. Neuendorf, *Sex on the Soap Operas: Afternoon Delight,* JOURNAL OF COMMUNICATION, Summer 1981).

15. *See* Orr, *supra* note 1, at 70.

16. *See Heroin: Abuse and Addiction* (visited Jan. 29, 1999). <http://165.112.78.61/ResearchReports/heroin/heroin2.html>.

17. *See The Contraception Report,* PATIENT UPDATE (American Academy of Obsterics and Gynecolgy) vol. VI, No. 3.

find out what the influences are. You have to talk to your adolescent.

There are many factors that are involved in the barriers to adolescent healthcare, including adolescent rights and confidentiality. The average practitioner in pediatrics, internal medicine, or family practice that cares for an adolescent does not have a clue that there are adolescent rights or laws of confidentiality. And what does that say? The confidentiality statutes, under federal statutes, state laws, and municipal ordinances, vary depending upon where you practice. The practitioners' institution can dictate their practice modalities. They can also have a theological affiliation that may in some way shape the advice and counseling that they give and the way they process the information that they have received.

The "confidentiality" that I am used to tells me that I have to notify parents before I see their children. There may be things that we talk about that are highly sensitive and private. However, at no point in time will I allow that child, and I consider all adolescents to be children, to discuss engaging in suicidal, homicidal, or family violence without notifying the family. I feel that the family has the right to know. In all other circumstances, we tell the adolescents that our conversations are private and confidential.

If the adolescent comes to me about psychiatric illness, depression, or other minor concerns, I try to work it out between the patient and myself. Once the patient and I feel that he or she is no longer competent or able to handle this without intervention, we then involve a significant other, hopefully the legal custodian. Then the custodian and I have the patient talk to us about drug experimentation and we encourage questions about drug use. As long as we have a good feeling that the patient is not involved in a way that is harmful to him or her, we try to work that out amongst ourselves. However, if we find out that the patient is in the drug trade, or involved with other illegal activities, such as stealing the family's possessions or cutting school, that is different.

As practitioners, we have to talk about sexual activity because if we do not, believe me, no one will. Oftentimes a child is too embarrassed to speak to the parent about these issues because of religious upbringing, lack of sensitivity of the parent,

or age of the legal custodian. Further, adolescents that live with grandparents, aunts and uncles, other relatives, or a foster family also feel uncomfortable discussing intimate details. Often, parents do not believe or refuse to believe that their little prince or princess is sexually active. So there are a lot of things that we have to talk about.

There are a multitude of influences in adolescence. The big one is puberty. Everything is blamed on puberty. "My hormones are out of whack." "My friends made me do it." "Everybody else is doing it, why can't I do it?" We always hear that from our children. As the old adage goes, "if your friends all wanted to jump off the bridge would you?" The response is: "if they were all wearing the right apparel, I guess I might because I want to be like everybody else. I don't want to be left out." "My body is going through changes." "I have horrible bumps on my face." "I'm ugly." "I'm fat." "I'm short." "Why am I the shortest one in my class?" "Why am I the tallest one in my class?" "How come we are both fourteen and he has a beard and I don't?" "Why can he wear designer jeans and I can't?" "Why do I have to wear these funny clothes when they get to wear Fila sweatsuits that cost $110?" "Why can't I be like them?" The parent tries to explain the value of a job, money well spent, and a hard-earned living. They do not understand and their friends cannot empathize because their friends have different family values. Every adolescent is different but they are all the same, because they all want to be the same. So, do not take it lightly when they tell you it is because of puberty because oftentimes it seems to be.

All joking aside, what we really try to do is get into the adolescent psyche. We call that a "psychosocial assessment" or "getting into adolescent heads." The mnemonic that we use for the psychosocial assessment is "H.E.A.D.S.," which stands for Home, Education, Activities, Drugs, and Sex. The adolescent may wonder why I want to know about their home environment. If I get a fourteen-year old boy, about six feet tall, who tells me that he lives with his sixty-six year old grandmother because his parents are not around, I get the sense that there may be some supervisory issues that we have to deal with. The grandparent may be just plain tired and unable to run after an adolescent as they would if they were younger. So, the answer

is that I can tell a great deal by asking a few simple questions, such as: Who do you live with? How many children live at home? Is there enough food? Is there enough shelter, enough running water? Do they have the basic necessities? Are they embarrassed to talk about it? Does that mold their activity or their actions? I try to find out if they are from this country. Do they speak the language? If the family lives here but their parents do not speak the language, then they do not get the reinforcement at home. They can not get help with their English homework if no one speaks English. Do they have a little brother or sister, who they feel is favored? Is the adolescent the middle child, the oldest child, or the youngest child? Is it safe in their house? Do they feel safe? Do they feel safe enough to trust me to tell me the things that are going on in their life? Is there physical abuse? If so, how often and for what reasons? Are there limits being set? Do they have a curfew?

In addition, the adolescent may wonder why I want to know about school and education. Again, this information can reveal a great deal. What is the educational level of their parents? Can the parents understand the pamphlets that we send home, the letters that they get from school, or the phone calls that they receive? There is a tendency to assume these things, but one cannot. So we ask these questions. We also want to know about the adolescent's education. A little trick that can be used is that the age minus the grade should equal five. If they are seventeen and in the twelfth grade, that's fine. If they are eighteen and in the twelfth grade, that's okay. But if they are eighteen and in the tenth grade, what happened to the other three years? Was the individual left back because of a learning disability? Were they left back because they were in jail for a year? Did they have a baby and drop out of school for a year? Was there not enough money to get to school? Did they feel embarrassed about the clothes they had to wear to go to school? What do they do in their spare time? Do they go to the library? Do they go to the Botanical Gardens? If they live in the Bronx, have they been to Yankee Stadium? I asked these questions when I worked at Lincoln Hospital and the answer was no, no, no, no.

A typical dialogue could be:

Q: Where do you live?
A: I live in that building on the corner by that big store.
Q: No, what is your address?
A: Well, I am on the corner of 167th and River.
Q: No, where do you live?
A: Oh, I don't know.
Q: What is your phone number?
A: We don't have a phone.
Q: How do I reach your parents?
A: I guess you will have to send them a letter.
Q: Can they read and write my language?
A: No.

We want to know about drug use. It has been shown that seventy percent of all high school seniors have been drunk at one point in time,[18] whether it is at homecoming, the prom, summer camp, or just hanging out drinking forty-ounce bottles of beer. You have to find these things out, find out what they are doing. Do they smoke marijuana? Do they smoke cigarettes?

Sex. We do not like to talk about that too much. It is embarrassing. We were not raised that way. We did not discuss that with our parents. It is one of those things you read about. Where did you learn about your sexual education? In a bathroom stall? On a corner of the handball court? Playing tennis with someone? Playing golf? How many of our adolescents do that? But, how did you learn? Where did you get your information? Did you get it in church or at home? I do not think so. I did not get it in school. We thought we did. They showed us some pictures, but no one talked about it. No one understood it. I had the misfortune of having a seventeen-year-old patient with two children who did not know what the word uterus meant. She had two children and did not know where her ovaries were. She had two children and did not understand her menstrual cycle. Whose fault is that? Where does the blame lie? We are not placing blame today. We are just trying to understand.

So, we ask these questions and try to figure out what we can do to help the adolescent. The majority of my job is preven-

18. *See* Orr, *supra* note 1, at 69.

tion. We have some preventive modalities that we like to use. We believe in patient education. We believe that they should be actively involved in their care. As Dr. Finegold mentioned about asthma,[19] they do not know that a chronic cough can be the first sign of asthma, that they should not smoke in the house, that there should not be pets. They do not know these things. There is no education. The parent does not know. If the parent does not know, how can they educate the child? So, we believe in patient and parental education. How much does the parent know about what is going on with the child? Do they understand what their child is doing? Who are their child's friends? Have they met their child's friends' parents? The more parents know about their adolescent's friends and their behavior, the more they will understand about what makes their adolescent tick.

We want to talk about contraception even though in certain arenas I cannot do so. We find a way to get the information disseminated. We want the adolescent to know that there are options. They have choices. Their choice will be predicated upon their family values, their education, and the healthcare system in which they participate or in which they fail to participate. We want to talk about family planning. We have a saying in adolescent medicine that no one plans to fail, but a lot of people fail to plan. That is what we like to tell our young people. No one plans to fail. You do not wake up and say, "Gee, I'm going to screw up today. By golly, I am going to get arrested. Yes I am." No, it just happens. You are in the wrong place or with the wrong people at the wrong time. You want to be "like Mike." You want to be popular. You have the wrong role models. Very few people make it in professional sports, but most of the children in the inner city have as their role models the rap star, the basketball player, the tennis player, and maybe now with Tiger Woods, the golfer. It is unrealistic. Education is the key. Nurturing a child's education is always important. So, we get to their families and we talk to them. Unfortunately, however, every once in awhile, we mess up. We are human. When

19. *See* Ira Finegold, *Global Initiatives to Minimize Asthma Morbidity and Mortality*, Speech given at the Pace University School of Law Health Law Symposium, *Children at Risk: Legal and Policy Barriers to Access to Health Care and A Healthy Environment for the Nation's Children* (April 23, 1998).

we do mess up, we have to intervene. One of the most common things I have to deal with in my practice is pregnancy. The other, is, sexually transmitted diseases. The lack of information out there is astounding. The things that I hear from teenagers about what they think is wrong, how they think it got that way, and what we need to do to fix it, is incredible. The misconceptions and the lack of information are also incredible.

In summary, we have to make everyone understand that all adolescents, regardless of how they appear, where they are from, or where they are going, need to have equal access to quality healthcare. They need someone to listen and someone to act on their behalf.