AMERICAN ACADEMY OF PEDIATRICS
COMMITTEE ON YOUTH

COUNSELING OPPORTUNITIES IN HUMAN REPRODUCTION*

PROBLEMS relating to human reproduction are among the critical issues of our time, and it is appropriate that pediatricians contribute to the solution of these problems. The changing dimensions of comprehensive pediatric care, more specifically the significant numbers of pregnancies being reported in young persons, support this position. For example, national statistics show that 44% of all pregnancies occur in persons under 20, and one out of four mothers on Aid to Families with Dependent Children in New York is pregnant before 16.

At least four roles can be identified for the pediatrician:

1. Genetic counseling: the pediatrician has already become proficient in giving knowledge to parents of the incidence of inborn errors of metabolism, chromosomal abnormalities, and other problems associated with genetic inheritance patterns.

2. Sex education: he often provides sex education to individual patients, families, and parents, in addition to teaching groups in his own practice and in schools, churches, or youth organizations.

3. Family planning and pregnancy counseling: he may provide assistance in these areas in behalf of the parents or adolescents. This assistance may involve a wide range of clinical advice and treatment, including the concept of spacing (rhythm method), contraceptive devices, or oral medication, whatever is considered most suitable for the individual. All alternatives for dealing with an unwanted pregnancy should be seriously discussed with the teenage girl and the other persons involved, including the parents if feasible. The pediatrician is in a unique position by the nature of his close association and relationship with the adolescent patient to provide this important personal service.

4. Sex counselor: the pediatrician can offer marital counseling to young parents or adolescents requiring premarital advice. (A recent California law, AB 402, requires all marital candidates under 18 years of age and their mates to receive some form of premarital counseling before issuance of a marriage license.)

Obviously, there can be no one answer; the extent to which the pediatrician involves himself in problems relating to human reproduction is dependent on himself and his clinical interests. The potential areas listed here for pediatric involvement are merely guidelines and not recommended modes of behavior. Because of its importance as a crucial issue, the American Academy of Pediatrics strongly recommends that each pediatrician examine his potential role in counseling opportunities in human reproduction. Furthermore, he should avail himself of current knowledge relative to this subject. Training in this type of counseling should be strengthened in pediatric residency programs. We owe parents and their children no less.

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* This statement has been reviewed and endorsed by the Academy's Council on Child Health.

VENEREAL DISEASE AND THE PEDIATRICIAN*

THE increase in venereal disease in this country, particularly in the past de-

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cade, is a well-known, although lamentable, fact. The situation has reached epidemic proportions. Gonorrhea is now the most common, reportable communicable disease and syphilis is the third. An estimated 2,500,000 cases of gonorrhea and 80,000 of syphilis[1] occur yearly. Fiumara and Lessell[2] reported, "there was a 202% increase in reported cases of primary and secondary syphilis in the United States" in the 12-year period, 1958 to 1969. Of major concern was a rise of 117% in cases of congenital syphilis diagnosed in infants under 1 year of age, which occurred in the same decade. The difficulty in developing accurate statistics on the incidence of venereal disease is well-known. Only 12% of cases treated by private physicians are judged to be reported to public health agencies.[3] Instances of syphilis are reported more accurately than gonorrhea, but only because laboratories inform health authorities about positive blood tests. However, epidemiologic control of the total venereal disease problem is nearly impossible at the present time.

The increasing occurrence of venereal disease in young people, particularly in young teen-agers, in the past decade is alarming. Gonorrhea and syphilis are seen in youth with material and educational advantages as well as in those from lower socioeconomic levels. Changes in patterns of sexual behavior and the availability of oral contraceptives and antibiotics have undoubtedly contributed to this health crisis. The casual attitude of many young people toward venereal disease is distressing.

The pediatricians' concern and responsibility extends into several areas of this increasingly serious threat to health. The first and uppermost relates to the prompt identification and treatment of infection. Traditionally, pediatricians have shifted the care of venereal disease to others, including dermatologists, urologists, venereologists, and public health personnel. The attitude, "this is not pediatrics," has prevailed. However, an epidemic is now in our midst and the pediatrician must respond.

The scope of pediatrics is rapidly changing. Pediatricians are encouraged to avail themselves of postgraduate courses and experiences to develop the expertise necessary for their expanded role. The Committee on Youth recommends that pediatric residency training programs provide a foundation of knowledge regarding sexual behavior, techniques of interviewing and counseling in sexual matters, and experience in gynecologic examinations if the clinician is to adequately provide health care to young people.

CARE OF THE NEWBORN

In this traditional role of prevention in matters of child health, the pediatrician has rightful concern with the unborn child.[4] Serologic testing of the mother for syphilis in the first and third trimester of every pregnancy is a responsibility in this direction. It is also necessary to conduct serologic testing on the cord and/or venous blood of the neworn infant. The importance of these measures is verified by the realization that only one-tenth to one-sixth of all instances of congenital syphilis are discovered in the first year of life.[5] Technical information related to differentiating between uninfected infants born of mothers who have syphilis and actively infected infants is beyond the scope of this statement.

The prevention of ophthalmia neonatorum caused by the gonococcus must be carried out in the immediate newborn period with regularity and vigilance. The time-honored Credé method, using a 1% silver nitrate solution, remains the method of choice,[6] because of the high incidence of sensitization resulting from instilling solutions of antibiotics. The prompt detection of gonococcal infection by culture at the time of prenatal visits is as important as serologic testing for syphilis during pregnancy. Fetal wastage and infection transmitted to the newborn infant provide sufficient cause for such procedures.

CARE OF THE ADOLESCENT

The pediatrician should consider a number of issues in dealing with venereal infec-

tion in the teen-ager. Venereal disease is increasing, and the need for heightened awareness of this fact bears repetition. Primary gynecology, and to an extent urology, has become a recognized responsibility of the physician taking care of young people. The U.S. Public Health Service has outlined a method for treating acquired syphilis as well as the congenital form.[7] Current recommendations for the treatment of gonorrhea have been developed by Caldwell *et al.*[8] The Academy, through its Committee on Infectious Diseases, has also developed programs for the control and treatment of syphilis and gonorrhea in its *Red Book.*[9]† Referral resources and the mechanisms for communicating with these resources must be well established for effective management of venereal disease in the teen-age boy or girl. The pediatrician who feels unable to provide service directly has the responsibility of referring his patients with suspected or known venereal disease for diagnostic and epidemiologic investigation and for treatment. Under these circumstances, the pediatrician should continue to have concern about the progress and ultimate well-being of this patients.

An increasing number of states are permitting the treatment of venereal disease in minors without the consent or knowledge of their parents or sponsors. Difficulties may arise when this legal provision is not available, although these difficulties are more often surmised than actual. Nevertheless, the role of the pediatrician in the social-legislative sense is self-evident. Uniform, noncategoric consent laws for the comprehensive care of young people, heretofore judged as minors in the legal sense, must be developed in this country. Hofmann[12] noted, "the solution of this problem is fundamental to the provision of health care of adolescents." Otherwise, physicians, hospitals, and their legal counsels are left "to inferentially interpret the body of common law and court rulings."[12]

Privacy and confidentiality are essential in the successful care of young people particularly those with venereal infection. Management must be accompanied by dignified, considerate care in which there is a nonjudgmental, concerned attitude. The development of trust between the teen-age patient and the physician must be fostered if efforts in epidemiologic control, counseling, and education are to be successful.

Every effort should be made to pursue the epidemiologic aspect of a given infection. We have already mentioned the difficulties encountered in this regard. The fact that reporting a venereal infection to public health authorities is mandatory in every state has not in itself led to reliable and consistently available data. Nor have these laws or regulations facilitated effective public health measures necessary to reduce the further spread of venereal infection. Public and professional apathy and reluctance contribute to this dilemma. Conversely, a reputation for zealous reporting or investigation inevitably results in the unwillingness of patients to come in for treatment. Venereal diseases have always carried a cultural stigma, which makes the cooperative efforts necessary for effective epidemiologic control difficult. Bringing in other professionals to investigate possible sources of infection is unacceptable to many patients. Teen-agers are particularly opposed to this and view it as an intrusion on their privacy and confidentiality. The effective engagement of the epidemiologic mechanism has to be carefully and discreetly managed by the physician or other professionals under his direction. A close interpersonal liaison between the physician caring for youth and public health professionals must take place to safeguard the rights of the individual teen-ager and achieve effective control of

† Among several acceptable forms of treatment at the present time, the following is suggested for those individuals who tolerate penicillin well: *Primary and secondary syphilis*—benzathine penicillin G, 2.4 million units intramuscularly in single dose. *Congenital syphilis*—benzathine penicillin G, 50,000 u/kg body weight intramuscularly in single dose.[10] *Gonorrhea*—aqueous procaine penicillin G. For males, 2.4 million units intramuscularly; for females, 4.8 million units intramuscularly, in single dose.[11]

further spread of the disease. However, identification of contacts is the only effective way to manage the spread of venereal infection at the present time.

The pediatrician or other physician caring for teen-agers has the additional responsibility of counseling and educating those with venereal disease as well as other young people with whom he has the occasion to provide information about any health matter, including venereal disease. The young patient's experience with venereal disease provides the pediatrician with an opportunity to make available counseling support directed toward strengthening psychosexual development and personality stability. Whenever possible, the resumption and reinforcement of positive communication between parents and teen-agers should be encouraged and constantly sought, although the illness and related matters should remain a private matter between the physician and patient. The physician must attempt to establish a continuing health care arrangement which includes preventive measures and assistance with educational and employment planning.

INVOLVEMENT IN HEALTH EDUCATION

Many programs are currently offered by public schools, private schools, churches, service organizations, and youth groups. The consultative services or participation of pediatricians in these community health education efforts are often solicitied. Guidance regarding sex education and behavior is clearly the primary responsibility of the parents.[13,14] However, teen-agers should not be denied access to information regarding the prevention and treatment of venereal disease. Well planned, specific programs concerning the nature and transmission of venereal infections should be an important part of the school curriculum. These programs should be taught by well qualified health educators. Printed materials should be made available to teachers and students (see Bibliography). In certain communities, young people have been effective in educating their peers.

SUMMARY

As a result of the sharp rise in venereal disease during the past decade, which seriously threatens the health of our young people, pediatricians must become actively involved:

1. in the prompt identification, treatment, and epidemiologic control of venereal disease in young people and newborn infants;
2. in developing and promoting social legislation related to the treatment of minors;
3. in encouraging and participating in effective educational programs for youth on venereal disease.

A heightened alertness to the possibility of venereal disease is required by every physician.

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