Children's Sexual Development and Privacy: A Call for Evidence-Based Ethical Policy

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Medical interventions involving a child's genitalia require careful evaluation. Context matters. Outside of medicine, apart from a small number of circumscribed situations (eg, diaper changing, help with bathing), adult viewing or touching of children's genitals is prima facie inappropriate and may in some cases be considered abusive. In contrast, a mechanically similar act performed by a medical professional in a clinical encounter is usually assumed to be ethically justified. However, while the range of psychological responses remains underinvestigated, it may still elicit uncomfortable emotions or connotations for the child.

Children's sexual development includes not only the physical development of secondary sex characteristics but also the psychosocial development of sexuality, including the identification and management of sexual boundaries as a means to self-integrity. Thus, regardless of how any particular child reacts to a medicalized intervention involving their sexual anatomy, adults, including doctors, owe it to children that any such intervention be ethically justified. Given the stakes involved, we argue that a necessary condition of such a justification is that the intervention in question must be adequately evidence-based.

Due to their professional role, doctors are socially permitted to engage with others' bodies, including their genitals, in ways that would be considered highly transgressive in other contexts. This permission carries with it a responsibility to ensure that engagement with patients' sexual anatomy is medically appropriate. For example, testicular examination in male neonates is routine within 72 hours of birth, and again at 6 weeks of age, to screen for undescended testes. This condition occurs in 1% of baby boys, and surgery is normally recommended to reduce the risks of future health complications such as infertility.[1] Similarly, if a child has symptoms (eg, testicular pain or a vulval rash), it would be considered routine for consent to be sought from the patient (and/or permission from their adult carer) for performing an examination as indicated.

Screening—the examination of individuals with no symptoms—should be performed only when the potential for benefit outweighs the potential harms.[2] Potential harms include not only side effects of interventions performed as part of screening (eg, mammographic breast screening involves biopsies, radiation, or health care costs) but also psychological sequelae (eg, stress, anxiety, and emotional distress). Given the lack of evidence of benefit and considering the potential for harm, screening of adolescent genital, sexual, or reproductive anatomy cannot be considered evidence-based. Indeed, as noted, there has not been adequate, much less systematic investigations into these potential harms, which is concerning.

We are concerned that within general pediatrics, clinical convention has been prioritized over evidence-based practice. Three policies of the American Academy of Pediatrics (AAP) reflect this notion. The first of these is the promotion of a sexual maturity assessment, based on the 5-stage Tanner scale, on a routine basis. The AAP's handbook on sexual maturity assessment notes that "[o]bservation of the development of genital and sexual hair growth in children is an essential part of their physical examination," as it provides "an important basis for the diagnosis and management of certain clinical problems that may arise."[3] An AAP Bright Futures handbook describes the evaluation as "a standard assessment for normal growth and development."[4] To justify this view, the authors note that exceptional cases of early or delayed puberty may point to endocrine issues indicating referral. However, this is screening, and it is not recommended by the US Preventive Services Taskforce (USPST). Nor is it standard practice in other countries

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such as the United Kingdom. The presumption in the United States is that screening will detect a problem earlier. However, this must be weighed up against the alternative scenario, where delayed development would have been naturally observed by the child and/or parents and brought to medical attention. The latter approach reduces false positives and costs, also avoiding unnecessary examinations. There is no high-quality randomized controlled trial evidence finding that such screening is medically justified.

There are also ethical concerns. Generally, these have focused on the use of the Tanner scale in assessing the ages of migrant children entering the United Kingdom and European countries, where child migrants have specific rights. Focardi et al highlighted previous criticism by UNICEF, adding that the use of the Tanner scale in age assessment

> is highly questioned, both for its poor utility and for the ethical issues raised by a practice that may result in intrusiveness or violating the right of children/adolescents . . . whose possibilities to refuse the procedure are very limited.[5]

With respect to migrant children, Sir Aynsley-Green, a pediatric endocrinologist and former Children's Commissioner for England, and colleagues noted that sexual maturity assessment "is highly intrusive and ethically questionable when conducted without medical or therapeutic benefit."[6] Child Rights International Network, a nongovernmental organization informing the United Nations on global children's rights abuses, describes the procedure as "an intrusive, degrading, and potentially traumatising examination."[7] In light of these concerns, we argue that Tanner staging should not be used as a blanket assessment (ie, screening well children), but rather should be reserved for particular cases where there is a medical indication established, for example, concern about precocious or delayed puberty. Indeed, such screening, in addition to its sexually sensitive nature, is not based on evidence and is not recommended by the USPST. As in any intervention, the decision for examination must be considered in light of the best interest of the child.

The second AAP policy of concern is the recommendation[8] to include routine gynecological examination as part of child and adolescent preventive care. The policy states that gynecological examination, "[a]t a minimum, examination of the external genitalia . . . as part of the annual comprehensive physical examination" in girls of all ages "is a key element in assessing pubertal status and documenting physical findings." Consequently, Robbins and colleagues noted,

> The genitalia are a major site of development and are especially important to examine in young adolescent girls, as physical and physiological changes occur concurrently with sexual development during this time.[9]

This statement is a non-sequitur: It hinges on an assumption, unsubstantiated, that development itself is of pathologic concern, indicating medical supervision is beneficial. We are aware of no data to support this view. (Note: In some cases, genital development examinations may even lead to unnecessary invasive procedures. A study of medical records in the Capital Region of Denmark[10] found that 95.0% of medically indicated circumcisions were performed for correction of phimosis [non-retractable foreskin]—concerningly, at a mean age that was 3.6 months below the mean age at which the foreskin becomes retractable.[11] It is plausible in this case that some boys' sexual development would have been better served by simply being left alone). The statement by Robbins and colleagues further reflects a viewpoint, stated by one pediatrician as early as 1967, that in light of "adolescent sexual changes, the physician can help pave the way for the teenage girl's continuing physical and psychological maturation."[12] This is concerning. While pediatric medicine may have a role in educating young people about safer sex, boundaries, and consent, it is difficult to understand how this could possibly involve an intimate examination in a healthy child. Furthermore, the potential for harm is significant.

Robbins et al[9] noted that genital examination in a sample of early adolescent girls "was best characterized [by the patients] as 'weird.'" Reasons included discomfort with nudity and concerns surrounding undressing or personal hygiene. These concerns speak to deeply rooted feelings surrounding sexual autonomy and privacy. We argue that such feelings are not an inconvenience for which strategies should be devised *around*, but rather that they deserve consideration in the decision of whether to implement such examinations into policy—and in turn, into practice—in the absence of compelling evidence. Indeed, for consent to examination (whether by the child or, by proxy, the adult carer) to be ethically valid, individuals need to have adequate information that expresses the potential for benefit and risk of the procedure: Without knowledge that the screening is poorly evidenced, informed consent cannot be obtained.

The third AAP policy of concern is the organization's latest (2012) circumcision policy, which states that the health benefits of nontherapeutic male infant circumcision outweigh the risks.[13] This viewpoint is anomalous among pediatric societies worldwide, including Canadian, Australasian, and UK/European societies.[14] However, even the AAP does not regard

infant penile circumcision as medically *necessary*—it is ultimately seen as an elective procedure that parents should be able to choose in the child's best interest, with attention to his social context and to cultural, religious, and family considerations. Nevertheless, whether it is appropriate for parents to request the procedure, or for physicians to alter a child's sexual anatomy without a valid medical indication, is increasingly debated among bioethicists.[15] Compounding the debate, routine, medicalized penile circumcision of neonates is rare in most countries with similar economic profiles and health care systems to the United States.[16,17]

The AAP Circumcision Task Force member Andrew Freedman acknowledged that the policy was "vigorously criticized" by international physicians and medical societies, and that the evidence regarding benefits and risks was "conflicting."[18] He responded to the concerns with an appeal to multiculturalism, adding that protecting parents' option to have their sons circumcised "was not an idle concern" for the Task Force "at a time when there are serious efforts . . . to ban the procedure outright."[18] This statement suggests that evidence-based policy may at times be influenced by non-medical sociopolitical factors. While not surprising, as this occurs in many areas of medicine, it is particularly concerning with respect to sexually sensitive interventions in minors, where, as we have argued, medical necessity is paramount.

Intimate procedures, with truly informed consent (or permission from adult carers), should be reserved for symptomatic children where medically indicated. Screening well adolescent children for their sexual development is not based on evidence. Tradition, convention, or eminence-based advice is not a justification. Medical organizations contribute toward cultural practices, health care beliefs, and health care activity. However, professional recommendations should be based on evidence. We hope that medical organizations currently recommending or tolerating intimate procedures, including surgeries and/or examinations to screen healthy children, will review their policies, not least to state the uncertainties, given that this information is necessary for consent. We also hope that future research and debate on the bounds of privacy among child and adolescent patients will follow.

Author Contributions

All authors contributed equally to this manuscript.

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