



Age Limit of Pediatrics

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Pediatrics is a multifaceted specialty that encompasses children's physical, psychosocial, developmental, and mental health. Pediatric care may begin periconceptionally and continues through gestation, infancy, childhood, adolescence, and young adulthood. Although adolescence and young adulthood are recognizable phases of life, an upper age limit is not easily demarcated and varies depending on the individual patient. The establishment of arbitrary age limits on pediatric care by health care providers should be discouraged. The decision to continue care with a pediatrician or pediatric medical or surgical subspecialist should be made solely by the patient (and family, when appropriate) and the physician and must take into account the physical and psychosocial needs of the patient and the abilities of the pediatric provider to meet these needs.

POLICY STATEMENT

Pediatrics is a multifaceted specialty that encompasses children's physical, psychosocial, developmental, and mental health. Pediatric care may begin periconceptionally and continues through gestation, infancy, childhood, adolescence, and young adulthood. In the guidelines for choosing pediatric experts for advisory panels, the US Department of Health and the Food and Drug Administration reference approximate age ranges for these phases of life, which consist of the following: (1) infancy, between birth and 2 years of age; (2) childhood, from 2 to 12 years of age; and (3) adolescence, from 12 to 21 years of age.¹ Additionally, *Bright Futures* guidelines from the American Academy of Pediatrics identify adolescence as 11 to 21 years of age,² dividing the group into early (ages 11–14 years), middle (ages 15–17 years), and late (ages 18–21 years) adolescence. The American Academy of Pediatrics has previously published a statement on the age limit of pediatrics in 1988,³ which was reaffirmed in 2012 and identified the upper age limit as 21 years with a note that exceptions could be made when the pediatrician and family agree to an older age, particularly in the case of a child with special health care needs.

Recent research has begun to shed more light on the progression of mental and emotional development as children progress through

abstract

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Drs Hardin and Hackell were equally responsible for developing and writing this policy statement.

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the adolescent years into young adulthood. It is increasingly clear that the age of 21 years is an arbitrary demarcation line for adolescence because there is increasing evidence that brain development has not reliably reached adult levels of functioning until well into the third decade of life. Students remain in college until their early 20s, and many continue to reside with their parents after graduation for financial as well as developmental reasons. In addition, because the number of children with special health care needs surviving into adulthood continues to grow, these patients are faced with limited access to health care services once the availability of specialized, supportive services terminates at age 21. Young adults with disabilities often have limited access to physicians who are trained to care for adults and also have the required knowledge of these problems originating in childhood.

Arbitrary restrictions on where patients in this transitional age range may seek care exist in many parts of the health care system. Insurers may set arbitrary limits on the age range for which a pediatrician may provide care, and these age limits may sometimes range as low as 18 years. Prehospital emergency care providers are generally equipped to provide care for all age ranges of patients.⁴ However, emergency departments, especially those with separate pediatric and adult facilities, may have policies directing patients to a particular unit solely on the basis of the patient's chronological age, and the same often occurs in hospital inpatient settings.⁵ Even pediatric practices may set an arbitrary age at which patients will be required to transition to adult medicine. Yet, pediatricians may be better suited than their adult-oriented colleagues to provide care for many patients outside of these age ranges, especially if patients have special

health care needs and if pediatricians have previously cared for them.

Just as the health care needs of each individual patient are unique, the age of transition to adult care is also unique. This transition,^{6,7} which should be part of health care discussions well before such a transition becomes necessary, should be based on many factors. Primary consideration must reside with the needs of the individual patient and the family situation. The training, abilities, and interests of the physicians involved must also be factors in these decisions. In particular, pediatric medical and surgical subspecialists could consider their purviews to be specific conditions, rather than a specific age range, and continue to provide care into adulthood in conjunction with adult primary care and surgical colleagues.^{8,9} In many instances, well-integrated, multispecialty groups are able to provide a seamless transition from pediatric to adult-oriented care and may thus set their own standards for this transition based on the competence, capacity, and availability of providers with the requisite expertise.

The establishment of arbitrary age limits on pediatric care by health care providers should be discouraged. Health care insurers and other payers should not place limits that affect a patient's choice of care provider solely on the basis of age. An extension of the guidelines, such as those put forth in *Bright Futures*, to cover recommended health care services for patients in their 20s should be developed. The decision to continue care with a pediatrician or pediatric medical or surgical subspecialist should be made solely by the patient (and family, when appropriate) and the physician and must take into account the physical and psychosocial needs of the patient and the abilities of the pediatric provider to meet these needs.

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