Adolescent Medicine

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The scope of adolescent medicine

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New developments in adolescent health have put the question ‘Who cares for British adolescents?’ squarely on the health agenda. It is therefore important to consider the special needs of adolescents in medicine, their place in medical practice, and how we care for young people in the different specialties.

Adolescent health is now topical. The House of Commons Select Committee on Health complained recently that:

Adolescent health needs, in regard to both health promotion and the treatment of sickness, are given insufficient priority and lack focus, with poorly developed services. Services for adolescents should be given greater focus and priority.

Responding to this call, the Royal Colleges have for the first time formed an intercollegiate working party to map out a strategy for adolescent health care in the UK. The working party should produce a preliminary report towards the end of 2000 (J Tripp; personal communication) which, it is hoped, will provide the impetus to improve the care of young people in many areas of the health services. Meeting the special needs of adolescents is increasingly being seen as part of quality care, and evidence-based guidance for caring for young people in hospital has recently been published in the UK. A very recent development is specialist adolescent medicine services in the UK, the first established in 1997 as a collaboration between the University College London hospitals and the Hospital for Sick Children in Great Ormond Street, some 45 years after the development of similar services in America.

Internationally, adolescent health is increasingly on the health care agenda. A European network for training in effective adolescent care and health (EuTEACH) has recently been established to develop adolescent medicine training programmes in Europe.

Key Points

- Most clinicians have adolescents in their practice
- Adolescents are in a state of continued development and have particular needs not shared by children or adults
- A non-judgmental approach should be taken to young people, with assured confidentiality and a willingness to include them in at least some decision making about their treatment
- Young people want a doctor whom they can respect as a doctor, not as a friend
- Young people sometimes use a ‘proxy’ complaint in order to be able to discuss other issues, such as contraception or sexually transmitted diseases, that they may feel unable to address directly
- Issues about drug and alcohol use and sexuality, etc are as important for those with chronic illness and disability as for healthy young people
- Showing the young person that some element of non-adherence is ‘normal’ allows him or her to ‘confess’ their non-adherence, and then allows you to think of strategies for improving it

The health needs of young people

In the US, adolescents are the one age group in which mortality and morbidity have not decreased in the last three decades. Diseases with social origins, such as suicide, accidents and drug-related illnesses, have replaced communicable diseases as the largest cause of mortality for those aged 12-17 years. The picture in Britain is likely to be similar, with rising mortality from social causes negating the fall in mortality from infectious diseases. Youth suicide has nearly doubled in male teenagers since 1975, and teenage pregnancy

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rates remain among the highest in the world. The government's Green Paper, *Our healthier nation: a contract for health*, mandates the health service to pay greater attention to the structural, economic, social and cultural determinants of health. This challenge may be most pertinent in adolescents, in whom social and cultural factors are perhaps more important determinants of health than in any other age group.

Because of these mounting problems, adolescent health is often seen to be the preserve of public health or primary care but, with the increased survival of adolescents with chronic illness and disability, adolescents and their problems can be found in all branches of medicine. The scope of adolescent medicine is the entire field of medicine for those aged about 10-20 years. Adolescent medicine is therefore a generalism, not a specialty. Most clinicians, except neonatologists and geriatricians, have adolescents in their practice, but not all are comfortable or skilled in dealing with them. American studies suggest that only about a third of physicians and paediatricians actually like working with adolescents, and about another third have little interest in adolescent care.

Adolescents have long been poorly served by the medical community, and the deficiencies in the provision of health services for adolescents in Britain have been repeatedly recognised since the Platt Report of 1959. However, only about 9% of health authorities and boards in the UK include specifications for adolescents in their planning guidance for health providers, and few general practices or hospitals make special provision for the needs of young people.

Improved training in dealing with adolescents is needed for doctors in all areas of medicine. I believe it is better to substitute 'adolescent medicine thinking' for 'adolescent medicine'. It is debatable whether more than a few adolescent medicine specialists are needed, but all doctors – from paediatricians to surgeons – certainly need to be trained to care better for young people.

**Major areas of importance for adolescent medicine thinking**

**Primary care**

About 70% of adolescents visit their general practitioner (GP) every year, providing an excellent opportunity for health promotion. Sadly, this is too rarely offered by GPs short of time in dealing with adolescents. Training in techniques for communicating with young people is effective in the clinical situation, and valued by GPs and patients alike. Other improvements that can be made to GP practices include:

- setting up specific adolescent clinics
- allowing young people to make appointments without giving their names or requiring a parent's consent
- providing appropriate teenage health promotion literature
- training practice staff in assuring confidentiality for young people

**Chronic illness**

Adolescent medicine thinking is particularly important for managing young people with chronic disease of any type. The burden of chronic illness in adolescence is increasing as larger numbers of chronically ill children survive into their second and third decades. Over 85% of young people with a chronic illness now survive into adolescence, and the prevalence of some diseases such as cystic fibrosis in UK adolescents has more than doubled in the last two decades.

The nature of adolescent psycho-social development (e.g. progression from concrete to abstract thinking, desire for separation from parents, identification with peer group, etc) can make management of treatment regimens very difficult, regardless of the disease or regimen. Poor adherence and poor clinic attendance are common and have an adverse impact on disease control.

Conversely, having a chronic illness of any type may retard normal adoles-
cent development, producing pubertal and growth delay, delayed social independence, poor body and sexual self-image, and educational and vocational failure. The importance of monitoring growth and pubertal development in young people with chronic illness well into the late teens and early 20s has been starkly illustrated in recent papers. Similarly, the importance of thinking proactively about helping young people with chronic illness and/or disability to develop independent adult living and vocational skills has been shown in longitudinal follow-up studies.

The effective management of the transition from paediatric to adult care is particularly important for this group. It is a particularly dangerous period for those diseases for which adult services or skills are poorly developed, as illustrated by the problems resulting from the treatment of grown-up congenital heart patients by adult cardiologists. Even in diseases where adult services are well developed and skilled, the transition period is a time when disease control is often poor and young people may ‘drop out’ of medical care for a time. It is important for all paediatric specialist clinics to have transition guidelines. Those where larger numbers of adolescents are transferring should develop an active transition programme with the receiving adult service. Preparation for transition should begin in early adolescence, and young people should move to adult care only when they have the necessary skill-set to survive independently in the adult service.

Psychosocial disorders and mental health

One of the most important areas for adolescent medicine thinking is in treating those disorders in which there is a major overlap between physical and mental health, such as eating disorders, obesity, and chronic fatigue syndrome. Perhaps more than at any other time, the developmental changes during adolescence mean that the psyche and soma are inextricably interrelated.

Doctors in any area of medicine dealing with young people must constantly be concerned with the mental health and adjustment to illness of the young people in their care. Adolescence (as opposed to adult life when a personality is ‘set’) is a time when many mental health problems and poor adjustment to illness can be remedied by working closely with the young people and their families.

Conclusions

Adolescent health and medicine needs to be one of the priorities of the NHS in the new millennium. Problems in the care of young people by the medical profession have led in the past to proposals for a new cadre of specialists in adolescent medicine to take over many aspects of health care for young people. Such specialists exist in the US and Canada, and to a lesser extent in Australia. Young people themselves (all too rarely considered) also favour specialist youth clinics run by specialists in adolescent medicine. However, a new specialty would further split the already fragmented delivery of health care, and contribute to the geographical maldistribution of doctors and health expenditure. The solution for the UK must be the development of adolescent expertise and ‘adolescent medicine thinking’ at all levels of health care delivery. This can happen only through greater attention being paid by all the Royal Colleges to training on adolescent issues (such as this CME series), and by the development of research and education centres for adolescent health within medical schools.

Specialist adolescent physicians should be jointly appointed between tertiary children’s hospitals and their associated adult hospitals to oversee the transition of adolescents with chronic illness from paediatric to adult care. These physicians should also form part of a multidisciplinary adolescent health centre in each region that spans hospital and community care, linking tertiary adolescent services with community drop-in health centres and health promotion in schools. Such centres should be truly multidisciplinary, bringing medical and allied health professionals together with educationalists, youth workers and other stakeholders in youth health. The mandate of the centres should include:

- training regional GPs, paediatricians and adult physicians in adolescent health care
- supporting community-based youth health initiatives
- advocacy for adolescent health issues within the region
- fostering research into the biological and psychosocial aspects of adolescent health.

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The adolescent with disability

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Everything is there when they're children — it's handed to you on a plate; but suddenly they get to nineteen and everything disappears — they get discharged from hospitals and then it's only if you have a problem that you can get a check up ... I mean, suddenly, they get better?

Mother of profoundly disabled young man

The term 'disability' refers to:
any restriction or lack of ability to perform activities in the range considered normal for a human being.

The impact of disability (the resulting handicap or disadvantage) varies with changing life situations, and depends on the attitudes of society and the extent of environmental adaptations (eg access to buildings for wheelchair users). Any chronic illness can be disabling, but the term 'disability' is most commonly applied to neurological and orthopaedic conditions, especially those shown in Table 1.

The principles of care for disabled adolescents are the same as those for other long-term medical problems in this age group, but some additional issues require special consideration. These centre around the decreased ability of disabled young people to achieve the main task of adolescence, the attainment of physical and emotional independence.

Variable severity of disability

The conditions listed in Table 1 vary widely in severity. For example, mild hemiplegic cerebral palsy or mild to moderate spastic diplegia may allow a young person to achieve an independent adult life, perhaps restricted only by an inability to participate in sports requiring speed and coordination. At the other extreme, a young person with severe four-limb cerebral palsy associated with learning difficulties, cortical visual impairment and epilepsy will require lifetime total care.

The need for autonomy

As children enter their teens, they seek greater autonomy in peer group interactions and sexuality. Their need and right to take increasing responsibility for