

Virtual Mentor

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Medical Education

Adolescent Medicine Training for Medical Students

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You are on duty in an ambulatory clinic and a 17-year-old comes in with a cold. He is well dressed and groomed. By looking at him, do you know if he is having unprotected sex? Or binge drinking on weekends? Or smoking cigarettes? Are you comfortable discussing these topics with him, and are you capable of doing so? If he is doing any of these things, do you know what to do? Do you know if you should share this information with his parents?

The adolescent age range is physiologically one of the healthiest times of life, but is associated with a high level of mortality and morbidity due to risk-taking behaviors. Accidents, suicide, and homicide cause 71 percent of all adolescent deaths [1]. The following statistics, based on data from the Centers for Disease Control and Prevention, bear that out.

- There is a 40 percent chance that your 17-year-old patient in clinic had more than 5 drinks in a row within the last month, and a 40 percent chance that he currently uses tobacco.
- There is a 34 percent chance that at some time he has ridden in a car with a driver who has been drinking.
- There is a 61 percent chance that he is sexually active, and he is in the age group most commonly diagnosed with sexually transmitted diseases.
- He also has a 13 percent chance of having seriously considered attempting suicide [1].

Adolescence is a time of life when patients develop habits that put them at higher risk for future chronic health concerns. The leading cause of preventable death among adults is tobacco use, a habit the vast majority of smokers started during adolescence. During the teen years, adolescents start to establish their diet and exercise habits, both of which contribute to major public health concerns like obesity and cardiovascular disease.

Unfortunately, adolescents are the largest group of individuals to underutilize preventative services [2]. They may see a physician only for a sports physical or treatment for a cold. They rarely present with a behaviorally related complaint, such as smoking or binge drinking. Therefore, something that seems as trivial as a cold may be your only opportunity to screen and provide interventions for high-risk behaviors.

When asked about risky behaviors, teens may initially feel uncomfortable talking to an unfamiliar adult. They are often unaware of their rights to confidential health care and are very concerned that what they tell a physician will be relayed to their parents. A key step in taking a history from an adolescent is to assure confidentiality by stating that discussions will remain between the doctor and the patient unless a problem becomes a threat to the patient or to others [3]. To a certain extent, state law determines which situations—statutory rape or child abuse—need to be reported to authorities. State law also dictates what services can be provided confidentially and without parental consent. Most states allow teens to consent independently to STD testing and treatment, pregnancy testing and prevention, substance abuse treatment, and mental health services.

Even when confidentiality is assured, many practicing physicians feel inadequately trained to screen and address risk-taking behaviors. Since about 1 in 7 US residents is an adolescent, physicians in virtually any specialty care for them. Only pediatrics, family medicine, and internal medicine require training in adolescent care, and pediatrics is the only residency with time dedicated to adolescent medicine [4-6]. Therefore, medical schools should take on the responsibility of teaching their students how to interact with and treat adolescents.

Teaching Adolescent Medicine

Ideally, medical schools incorporate training in adolescent medicine throughout their curricula. Since adolescent medicine focuses heavily on addressing health-related behaviors, many of which can be difficult to discuss, training should be highly experiential and case-based. During the preclinical years, adolescent medicine can be included in a patient-physician communication course and a behavioral health curriculum. During the clinical years, opportunities for encounters with adolescents are present during multiple rotations, including pediatrics, internal medicine, and family medicine, but also obstetrics and gynecology, emergency medicine, and surgery. Every opportunity to learn more about adolescents should be emphasized.

Communication

A preclinical communications course can teach students how to structure an interview with an adolescent so that it is patient-centered and sufficiently comfortable to allow discussion about sensitive topics, such as sexuality or substance abuse. The interview should start with topics the patient wants to discuss? the sports in which he or she participates, for example. While building rapport, the interviewer will discover the patient's many strengths and can provide encouragement for positive, healthy behaviors. The interviewer, having made the teen comfortable, can now address more sensitive psychosocial topics [3].

An effective way to include important psychosocial questions in the history is do a "HEADSS" review of systems. HEADSS is an acronym that stands for Home, Education/Employment, Activities, Drugs (including smoking and alcohol use), Sexuality, and Suicide/Depression. Following the HEADSS acronym, an interviewer can ask questions starting with least threatening topics and progress to the most uncomfortable or threatening topics [3]. (See Clinical Pearl in this issue.) These skills

have been successfully incorporated into curricula using standardized patient encounters or by students role-playing with each other.

Behavioral health

During a behavioral health course, students can learn how to counsel teens on their risk-taking behaviors. Teens are notorious for their selective hearing when an adult is lecturing them on how they should change, so be sure to identify the patients' own agendas with regard to their behaviors, and discuss behavioral methods such as the stages-of-change model [4]. This will allow student clinicians to help move a patient toward or through a behavior change as appropriate. There are successful programs in the literature using problem based learning methods, case studies, and standardized patients.

Clinical aspects

Adolescent care is often provided in a multidisciplinary setting. In clinical years, students should take advantage of opportunities to learn from the primary care physicians, psychiatrists, psychologists, and nutritionists who provide care to adolescents. When caring for adolescent patients, third- and fourth-year students can hone their history-taking skills, particularly with regards to adverse health behaviors. Students may also have the opportunity to practice their behavioral counseling skills. For students who desire a dedicated experience in caring for teens, most medical schools offer a fourth-year elective in adolescent medicine.

Conclusion

Adolescence is a period of great change physiologically, psychologically, and socially. Most adolescents make the transition to adulthood without major problems, and it is a time of intense self-discovery. They are filled with tremendous energy, hope for the future, and a playful outlook on life. Learning to be a positive influence and to guide a teen to healthy choices is fulfilling and fun, and it can have a lasting and important impact for the rest of the teens' lives.

References

1. Centers for Disease Control and Prevention. Surveillance Summaries, May 21, 2004. *MMWR*. 2004;53(No. SS-2).
2. Ziv A, Boulet JR, Slap GB. Utilization of physician offices by adolescents in the United States. *Pediatrics*. 1999; 104: 35-42.
3. Neinstein LS, ed. *Adolescent Health Care: A Practical Guide*. 4th ed. Philadelphia: Lippincott Williams & Wilkins; 2002:65-66.
4. Prochaska JO, Norcross JC, DiClemente CC. *Changing for Good*. New York: Avon Books; 1994.
5. Accreditation Council for Graduate Medical Education: Program Requirements for Residency Education in Pediatrics, Effective July 2001. Available at: <http://www.acgme.org>. Accessed January 14, 2005.
6. Accreditation Council for Graduate Medical Education: *Program Requirements for Residency Education in Internal Medicine*, Effective July 2003. Available at: <http://www.acgme.org>. Accessed January 14, 2005.

Resources

Adolescent Medicine Teaching Resources. Available at: www.usc.edu/adolhealth. Accessed February 3, 2005.

Emans SJ, Knight JR, eds: Bright Futures Case Studies for Primary Care Clinicians: Adolescent Health. Boston: Bright Futures Center for Education in Child Growth and Development, Behavior, and Adolescent Health; 2001. Available at: <http://www.pedicases.org/home.adp>.

Information on Standardized Patients: <http://www.aspeducators.org/>. Accessed: February 3, 2005.

Prochaska JO, DiClemente CC. Stages and processes of self-change of smoking: toward an integrative model of change. *J Consult Clin Psych*. 1983;51:390-395.

Prochaska JO, Velicer WF. The transtheoretical model of health behavior change. *Am J Health Promo*. 1997;2:38-48.

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