

Addressing the in-between generation

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—Midway between the Galapagos and the Marquesas

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5° 53' S, 114° 50' W

I finally have the time to have the time. I have been telling myself that I should write for ages. This subject is important to me. I care about it. But I find writing so hard. It is a calm day and the sea is so inviting. In I go! As seafarers used to say when embarking on a perilous journey, "Godspeed."

Ten years have elapsed since the College of Family Physicians of Canada's Task Force on Adolescent Health published its report.¹ The report was endorsed by the College, and I wonder how its recommendations have been implemented. Many recommendations had to do with training, final evaluation of residents, community involvement, and much-needed changes in the attitudes and behaviour of practising physicians.

The report explained the importance and relevance of the work that family physicians do with adolescents, and this explanation is still valid today. The World Health Organization report cited in the task force report indicated that, since the early 1960s, adolescents comprised the only group for which indicators of mortality and morbidity had deteriorated. Ten years down the road, I do not believe that these indicators have changed or that efforts to respond to them have been enough.

Much has been written and said about adolescent behaviour, suicide rates, deaths in motor vehicle accidents, substance abuse, and increasingly sedentary activities. All of these conditions are "preventable." They are also risk factors that pave the way for adult disorders. Cures for and research on these adult disorders appear to be adequately funded.

A few years ago, I found that about 1% of the money from the Quebec agency that funds health-related research, the Fonds de recherche en santé du Québec, went to research on adolescents. From the funding for research in child health from the Quebec agency for social research, the Conseil québécois pour la recherche sociale, approximately 80% went to research on children 0 to 6 years old; 15% to research on children 6 to 12 years old; and

a mere 5% to research on adolescents (and most of that was focused on the area of delinquency). It goes without saying that there is not enough research—or funding—to improve our basic knowledge or our clinical knowledge of this population.

Quite apart from research, as diligent, attentive family physicians, we should be capable of caring for our adolescent patients, and yet....

Workshop on adolescents and depression

As a leader of the workshop on adolescents and depression offered jointly by the Quebec College of Physicians and the Quebec College of Family Physicians, I have talked to many Quebec physicians about this issue. This workshop recognizes how difficult it is to identify depression in adolescents and is designed to provide physicians with the tools they need to screen and care for depressed adolescents. Approximately 2000 physicians have requested this workshop; I like to think that it fills a need. Workshop participants not only increase their knowledge, but also often confide that consultations with adolescents make them uncomfortable.

And yet, in many ways, adolescents are no different from our other patients. They bring us their suffering, illness, and disease. Due to their age-related vulnerability, however, they enter our offices seeking reassurance that we will take them seriously. It is as if they were asking, "Can you accept me as I am?" and as if they were saying, "I'm looking for a good doctor who doesn't think of himself or herself as my parent or as my friend. I want my *own* doctor." They also enter our offices not knowing how to conduct themselves during a consultation. They often need

doctors to act as educators, guides, and strategists in helping them to understand this environment.

Some readers will no doubt remark that I have not mentioned the role of parents, and rightly so. Even when they are not physically present, parents cannot be dissociated from the adolescents who come to our offices. They are usually the best allies of adolescent patients who, unfortunately, are the last people on earth to be aware of it. It is our job to help our patients “integrate” their families while at the same time distance themselves in order to become adults who can think independently. Once again, we have a facilitating role by helping our adolescent patients step back and see what is true for them. Sometimes we can act as mediators.

These clinical considerations and the special relationships that we can develop with our adolescent patients lead me to a more general comment on the College’s position and to an ethical, rather than a professional, consideration.

Are we failing our adolescent patients?

In December 2001, an editorial on the “fifth principle” of family medicine was published.² The author wrote that, increasingly, ethical and community responsibilities must be integrated into the role of family physicians. She also took a strong stand on the advocacy role that we can play. Where these roles are concerned, I feel that we have failed our adolescent patients!

In the training we provide to family physicians, are we sending the message that adolescent health care is important? To my knowledge, the written examination and the simulated office orals do not deal extensively with adolescence. During our on-site surveys, we check to see how many babies residents are delivering, how many children and seniors they are providing with continuity of care, and, more recently, how many heroin addicts they are treating. Is there the same accountability for our adolescent patients? We ensure that our geriatric patients are cared for in their own settings, but do residents see adolescent patients in schools or in reception areas of youth centres (which, incidentally, have the highest concentration of teenage suicides)? What about youth centres? In all of these

places, meaningful interventions with individuals and groups are possible. These activities were recommended by the task force in its report.¹

Similarly, the learning objectives for adolescent care are always wedged in between pediatric care and adult care. Curriculum review committees do not appear to be particularly interested in the specific needs of adolescents or in the training medical students need to care for them. I am always taken aback by what happens whenever I spend time in the classroom. I meet adolescents who are depressed, anorexic, at risk, and vulnerable.

Many family physicians are interested in adolescent care. Even though I have heard physicians across the country say that adolescents take up too much of our time to be “profitable” in a fee-for-service context, many physicians work for nothing with adolescents living on the street or in shelters. Many physicians work in schools and youth centres. Could our health care system recognize that these interventions respond to needs that are unique and that going out into the community is one of the ways to reach adolescents and help them? If so, we urgently need a system to pay physicians for this “clinical” work. This was another of the task force’s recommendations.

As a patient population, adolescents are vulnerable. As a professional group, we have failed to provide them with comprehensive, ongoing care. If family physicians are effective clinicians, if family medicine is community based, and if family physicians are a resource to a defined practice population, *I must—we must—improve our delivery of services to this undertreated and perhaps maltreated population.* ❁

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The opinions expressed in editorials are those of the authors and do not imply endorsement by the College of Family Physicians of Canada.

References

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