The discipline of adolescent medicine in BC

Last spring a significant milestone in adolescent medicine in Canada was reached—the Royal College of Physicians and Surgeons endorsed it as a subspecialty within pediatrics.

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In the spring of 2007 a significant milestone in the furtherance of adolescent medicine (AM) in Canada was reached. The Royal College of Physicians and Surgeons (RCPS) endorsed recognition of the discipline of AM as a subspecialty within pediatrics. This was the culmination of many years of preparatory work by the members of the Adolescent Medicine Committee of the Canadian Pediatric Society.

An unpublished paper by Peter Spohn (1960) represents the first written proposal for establishing a clinical and academic AM program in BC. Today, there is general recognition that the primary care needs of contemporary adolescents are provided for by family physicians or community health nurses while those in social or emotional crisis or with chronic health conditions are less well served and would benefit from a program such as that advocated by Spohn.

AM has evolved into a multidisciplinary biopsychosocial model of care and research and education and is heavily influenced by its roots in the US. The few established programs in Canadian pediatric centres such as in Montreal and Toronto emulate the US model and stand to benefit the most by the RCPS decision. Pediatric teaching hospitals in other Canadian cities have yet to develop and sustain their own AM programs. Perhaps acquiring subspecialty status will stimulate and sustain AM across Canada.

In BC, the Department of Pediatrics at UBC has, since the days of Spohn, tried to sustain an interest in AM. It has not been the only clinical or academic discipline to do so; family practice, nursing, obstetrics and gynecology, psychology, psychiatry, public health, and epidemiology are among the list of contributing disciplines noted in the 1995 report of a committee chaired by Dr Carol Herbert.[1] Dubbed the COUTH (YOUTH) report, it identified four key adolescent health issues in BC (see the **Table**). The RCPS decision provides an important opportunity for academe in BC to respond by advocating for the development of a unique, made-in-BC model of AM.

Examples of achievements in AM in BC that can provide a base upon which to build include following:

- The creation of a multidisciplinary curriculum in AM (National Training Initiative in Adolescent Health (NTIAH) co-developed by the Departments of Family Practice and Pediatrics).
- Introductory and third-year courses for medical students and a 1-month elective for pediatric residents.
- A transition model (OnTrac) of care for adolescents with chronic conditions (also eating disorder services and community-based youth clinics).
- Partnering with the McCreary Centre Society in province-wide population-based surveys of adolescent health and risk behaviors.
- Partnering with the School of Nursing (UBC) and the Michael Smith Health Research Foundation in the appointment of Dr Elizabeth Saewyc in a leadership role in adolescent health research.

Table. Adolescent health issues in BC as identified by the Council of University Teaching Hospitals (COUTH).[1]

• Lack of age criteria and age-specific policies and programs.
• Absence of a mandatory adolescent health curriculum within health sciences at UBC.
• Minimal adolescent health research and adolescent health research funding.
• Need to establish and confirm the academic home for adolescent health.

Other steps forward include the creation of a Division of Adolescent Health (DAH) by the Department of Pediatrics (1990), hosting a major international conference on adolescent health in Vancouver (1995), and an AM theme issue of the *BCMJ* (1998).

Implications

Subspecialty recognition for AM comes at a critical stage in the history of pediatrics in BC. It comes at a time when its DAH has no full-time head

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and the program's sole full-time AM specialist is moving to Calgary. These recent developments have important training program and accreditation implications for UBC.

The creation of subspecialties has important financial and human resource implications for faculty departments and teaching hospitals. These include funding the evaluation and certification of subspecialists in AM, creating more training modules, and systematically evaluating the quality of learning opportunities provided. Nowhere is this more important than in training physicians in the primary care of adolescents. It is difficult to expose trainees to common adolescent problems such as sports injury, obesity, and reproductive health concerns. Demonstration of developmentally appropriate approaches to adolescents is, at the pediatric resident level, a challenge, and opportunities for pediatric trainees to take ongoing responsibility for the care of adolescents are hard to find. Subspecialty training programs in AM should respond to these challenges by becoming less bound by the four walls of the pediatric tertiary care centre and more open to community-based learning options. All this requires leadership and funding.

Unfortunately, when it comes to competing for funds, community-based youth programs are the last to be funded and the first to be cut. Within academe, programs for adolescents have been placed low on the tertiary care totem pole and their resources and caseloads have been absorbed by other stronger, hospital-based services. For example, bed pressures at BC Children's Hospital (BCCH) have meant that, while the hospital's official age limit for admission is 19, practically speaking it is under 16. As a consequence, adolescents aged 16 to 19 are often in limbo as their needs are bounced between the specialty clinics, emergency departments, and inpatient units of the pediatric and adult units. A subspecialty in AM will need to see a shift in our thinking about age limits and a greater commitment within the health care system to serving the needs of all youth.

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Providing consistent leadership in AM is one of the challenges that academe in our province will need to confront. To date, leadership has been provided by individuals with strong commitment to the needs of adolescents but varying commitment to building sustainable training programs. Some leaders have been inspirational while others have been less transformative and have chosen more of a "caretaker" role. The challenge for BCCH and the Department of Pediatrics will be to create the conditions that will provide strong and sustained leadership. This will require building a tradition of academic and clinical excellence and putting together a team of three to four academically oriented, research-minded specialists in AM.

The provincial formulas for funding of AM activities will also need strengthening as it is unreasonable to expect to successfully recruit and retain academic leaders if they are forced to rely on clinically derived income. Nor can government or the BCMA expect the current fee-for-service structure to be an incentive to trainees to enter subspecialty training in AM. Alternative payment mechanisms will be needed to open doors to career opportunities in AM and sustain critical mass or build networks of adolescent-oriented subspecialists.

Those entering the field will need to be encouraged to continue their professional development by acquiring other skill sets. For example, practitioners might conduct clinical or epidemiologic research, become part of a specialized multidisciplinary clinical team or consulting service, or develop innovative educational or evaluative methods. These and other special functions will need to become part of the career package if AM is to become a legitimate subspecialty.

Conclusion

The endorsement of adolescent medicine as a pediatric subspecialty is a step forward and can be an important opportunity for all parties interested in advancing the youth agenda in BC to agree to engage in a cooperative, synergistic enterprise on behalf of adolescents with health problems. While one group—pediatrics—has formalized itself and gained recognition of AM as a subspecialty, it is hoped that all disciplines can benefit from this achievement.

Reference

1. Council of University Teaching Hospitals. COUTH report: The role of Vancouver hospitals in meeting youth health needs: Vancouver: Council of University Teaching Hospitals Planning Committee Report, 1995.

Further reading

Pinzon J, Tonkin RS. Meeting the health needs of BC's youth: The evolution of health and human services in BC. In: Tonkin RS, Foster LT. The Youth of British Columbia: Their past and their future. Victoria: Western Geographical Press, 2005: 51-62.