Adolescent Medicine in Primary Care

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ADOLESCENT MEDICINE IN PRIMARY CARE

This book is for my sons,
Walter and Blair

preface

Most adolescents who are concerned about their health turn first to primary-care clinicians for help. Their choice is a fortunate one because adolescent primary care harmonizes closely with the customary practice of pediatrics, internal medicine, or family medicine. In each primary-care setting, the harmony originates in the developmental, physiologic, and clinical counterpoints that appear when patients who are in the transience of adolescence are provided with care by a clinician who also cares for patients who are in adjacent life stages.

The pediatric clinician is reminded that childhood development and health have long-range effects that are seen and felt during the adolescent years, and the clinician also discovers that when some appropriate changes are made in the conduct of care, it is possible to contribute effectively to the care of the pediatric patient during adolescence. The clinician is also afforded the opportunity to witness, and sometimes to guide, the adolescent's course. For the clinician in internal medicine, the provision of care to adolescents makes it possible to observe the physical growth, sexual maturation, and social changes that catapult the prepubertal child into maturity and give rise to several groups of clinical entities that prevail during the adult years. The practice of family medicine, which has a broad view of human development and clinical care, is, of course, incomplete without the generational link provided by adolescence.

Though adolescent primary care belongs in each of these major clinical disciplines and can be practiced comfortably with any of them, it is not quite the same as any one of them, and this book deals with the differences. As work has progressed on this book, several criteria have consistently been employed in determining the scope of the contents.

Most important, perhaps, subject matter has been chosen which has considerable specificity for adolescence. Those clinical conditions that affect children or adults, as well as adolescents, and that are usually described comprehensively in pediatric- and internal-medicine texts are not included, while aspects of care, physiologic change, and clinical disorders which are unique to, or remarkably common in, adolescence have been selected for attention. In addition, the inclusion of material has been balanced as much as possible to satisfy the criteria of essentiality and practicality. Therefore, any material that is likely to be needed by the clinician who cares for adolescents every day has been included; and the contents have been critically assayed for their clinical usefulness. Application of the latter criterion has been especially difficult in the first section, which considers the conduct and organization of adolescent primary care. It has been assumed that clinicians will have general clinical skills to which this information can be appended and that those who wish to develop a more extensive theoretical understanding of the psychology of adolescence will enjoy exploring the rich fund of information already available elsewhere.

The second section covers, in some detail, the process of sexual maturation and the physical growth that accompanies it. With a thorough understanding of the physiology of adolescence, the clinician should be prepared for the clinical disorders of adolescence which are considered in the third section.

While it has been designed to convey specific, essential, and practical information to the clinician who is interested in caring for adolescents, this book is intended to serve as a guide to clinical work rather than as a set of formal instructions. As a guide, the book will accomplish its purpose if it can provide the clinician with a grasp of what is known that is relevant to adolescent primary care and thus equip the clinician for new clinical adventures.

Many others have helped to make this book possible. Adolescents, through their participation in care, have contributed much of value. Colleagues with varied clinical experiences have asked questions that have illuminated many of the gaps in our understanding of adolescents and have provided information that has begun to fill in some of these gaps. Charles D. Cook, M.D., and Howard A. Pearson, M.D., as chairmen of the Department of Pediatrics of Yale University School of Medicine, have provided for the inception and development of an adolescent service which is fully integrated into a pediatric program. As work on this book progressed, Ellen Anyan transformed countless pages of

unruly manuscript into presentable form; Betty Murray not only produced the final manuscript but also shared in the development of the adolescent service to which her wisdom and humor have been invaluable; and my family responded with interest and patience.

Walter R. Anyan, Jr, M.D.

contents

part one
the organization and conduct of adolescent primary care

To organize and effectively conduct care of the adolescent, the clinician assumes several clinical responsibilities, each of which is considered in the chapters of this part. Chapter 1 focuses on the basis of adolescent primary care, the clinical relationship of the clinician and the adolescent. Under the best of circumstances, this relationship forms and develops as a partnership that serves the adolescent's developmental needs and clinical requirements. The maintenance of the clinical partnership and its effectiveness in meeting the adolescent's various needs can be influenced by a variety of ways in which adolescents present themselves for care as well as by the responses made by the clinician to each presentation. These aspects of care are discussed in Chapter 2. Chapter 3 describes several changes that occur in personal and interpersonal spheres during adolescence. Knowledge of these changes can enhance the development of clinical relationships with adolescents, the understanding of various complaints that they have, and the logical and efficient assessment of adolescent development. The construction of a data base for the adolescent is briefly outlined in Chapter 4. Each data base should convey a useful understanding of the patient through information about the patient's growth and development, family constellation and medical history, and the patient's medical history, social development, and academic life. A grasp of the patient's past and present ability to function in the family, social, and

academic arenas is a major goal of the data base. The clinician can employ a variety of screening measures to identify subclinical or asymptomatic disorders in adolescent patients. Some of the screening measures discussed in Chapter 5 have immediate importance to the adolescent, while others may produce clinical information with which disorders of later life can be prevented or ameliorated.

chapter one
the adolescent and the clinician

Children certainly sense when a clinician is interested in them apart from their health needs, and they usually respond positively to such personal interest. As they grow older, children need more privacy and require less immediate emotional support from their parents during clinical visits, and they acquire a greater ability to exchange information with a clinician. These developments also indicate that the parents' involvement in the health-care process can change and that the relationships between patients and their clinicians can become stronger. As patients approach and move through adolescence, the clinician who wishes to continue caring for them can adjust the manner in which care is conducted so that the patients' developmental needs will be met. This chapter is concerned with several evolutionary aspects of the relationship between the adolescent and the clinician.

Perhaps the principal difference between clinical care of the younger child and that of the adolescent consists of a noticeable shift in the members' views of the relationship. For the adolescent, the relationship provides an opportunity to draw the clinician into active participation in working through various developmental tasks and dilemmas. To enhance this opportunity and to facilitate general health care, the clinician acts to bring the adolescent into full partnership in the evaluation, understanding, and management of concerns about health and illness. In general, the clinician may be able to encourage the adolescent to take advantage of the opportunity to use the relationship by indicating a nonjudgmental, unmistakable interest in the adolescent as a person as well as accessibility when needed. Establishing a middle ground between being too distant from or too intrusive upon the ado-

lescent, the clinician occupies a position to be helpful in matters of health and in providing guidance in other areas. The adolescent usually chooses whether, and when, to make use of the clinical relationship.

Adolescents often have to learn how to use a clinical relationship to their benefit. Some, who initially view the relationship as one in which the clinician is the responsible member, may expect to be cared for with little involvement on their part; others, who appear rather authoritarian, may inform the clinician of specific needs they have identified, such as "water pills" or "a gym excuse," and may not appreciate the need to consider other information. For many others, it may be difficult to comprehend how talking about issues drawn from everyday life can be helpful, particularly when they are accustomed to presenting symptoms, having a physical examination, and receiving medication. Being aware of the adolescent's lack of experience in participating in care, the clinician will not regard the patients described briefly above as being uninterested, overbearing, or unintelligent. The clinician will realize that it is the best the adolescent can do under the circumstances. The clinician can then guide the adolescent in forming a stronger relationship in which the responsibility for health care is shared with the clinician.

In most instances, the adolescent does not complete one visit without developing some plan for the next visit, whether it is for the following day or for the next year. Although they may need some guidance, adolescents should participate in arranging return appointments after considering both clinical need and convenience. With proper planning, visits will not be scheduled too soon and "forgotten" by the adolescent; nor will they be too far apart, making progress slow and suggesting that the clinician is not very concerned about the adolescent's problem. Between visits, both the adolescent and the clinician can use the telephone to inform each other about test results and progress or difficulty in various areas.

BEGINNING A RELATIONSHIP

The relationship with the patient begins with the contact made by the patient or the family to arrange care, and it really develops with the first clinical visit. The physical setting of the clinical facility must be one in which care can be provided comfortably to the adolescent. While

it is unnecessary to provide a separate or specially designed waiting area for adolescents, chairs and examining tables should be large enough for the patients. The personal reception given adolescents on their arrival should be interested, respectful of their maturity, and indicative of the tone of the clinical care that follows.

For most adolescents, both the adolescent and the parents contribute to an understanding of the adolescent's current problems and the development of a data base. With a few obvious exceptions, the clinician should conduct the initial interview with the adolescent. In this way, the clinician offers the adolescent an opportunity to become involved in partnership in matters of health and illness by lessening the adolescent's feelings of being helpless or dependent and by encouraging the adolescent to assume increased responsibility for, and to develop more knowledge about, these important matters. In addition, the clinician obtains a firsthand, spontaneous perspective of the patient and the views that the patient has of current problems, medical history, and social environment.

In some instances, parents expect to be seen first or to accompany the adolescent to the interview. Their expectation may have several sources. It rests on past custom; on a perception that the adolescent, who for years has dealt successfully with adults outside the family, is unable to provide a cogent history; or on a need to be intrusive or a wish to maintain the adolescent's dependency. More often, the parents have simply not considered that the adolescent's being seen alone is a viable and appropriate alternative to the clinical arrangement usually followed during childhood. Of course, the younger adolescent usually enjoys this innovation in care, while the older adolescent generally expects it.

Under circumstances in which the parents of an adolescent have major concerns about the adolescent's emotional or physical well-being and make them known in advance of the patient's being seen, it can be very helpful for the clinician to interview the parents first. Some of the clinical information can be organized during the interview, and a tentative approach to the evaluation of the clinical problem can be developed. Both can improve the clinician's ability to care for the adolescent and may also reduce an uncomfortable amount of parental anxiety.

Other history gathered from the parents can be used to fill in details in the developmental data and early medical history as well as to provide additional perspectives of various aspects of the patient's life and of the family constellation.

PATIENT COMFORT AND CONFIDENTIALITY

As a free exchange of information between the adolescent and the clinician is the most important part of a successful relationship, it is important that each one be sufficiently comfortable with the other to communicate effectively. It can be reasonably assumed that the clinician who wants to care for adolescents, who is cognizant of their development and their clinical needs, and who does not attempt to mimic the adolescent should have no reason to be apprehensive about the interaction that will occur with the adolescent. In addition, the clinician can influence two specific factors that can increase the adolescent's sense of comfort. One factor includes the warmth and openness with which the clinician receives the adolescent, and the other concerns the clinician's ability to gage the pace at which the adolescent is able to proceed in discussing the current problems and relevant history. As adolescents naturally think of themselves as persons rather than patients, the clinician who allocates some time at the beginning of each interview to talk with the adolescent, as one would with a friend, accomplishes several purposes. One consists of providing the adolescent with an appropriate reception as well as a chance to work comfortably into clinical matters. In this way, it is frequently possible to avoid the development of tension in the interview. The clinician must remain alert for the appearance of tension later on and take appropriate steps to alleviate it. Another purpose of such exchange is to begin to form impressions of general function for the patient's data base.

Another important aspect of adolescent primary care involves providing the adolescent with an impression of the confidential nature of the clinical relationship. It is best to begin an interview with the understanding that the information exchanged between the adolescent and the clinician is privileged. Often, the clinician's conduct of the interview demonstrates that confidentiality is respected, and it may not always be necessary to enumerate specific assurances of confidentiality. In certain circumstances, however, more precise information about confidentiality should be provided to patients. The adolescent who has experienced difficulty in relationships with intrusive parents or disappointment with clinicians who inappropriately divulged information in the past may need assurance of confidentiality. Similarly, when an adolescent presents for care at the request of someone outside the immediate family, the clinician and the adolescent should agree about the transmittal of data that are obtained. Guarantees about

confidentiality are subject to several important modifications. One condition is that confidentiality can not be usefully preserved under circumstances that endanger the adolescent's life or well-being (or those of someone else). Another condition that is commonly overlooked concerns the clinician's professional need to discuss the adolescent's condition with other clinicians. In addition, the clinician can offer to discuss, with the adolescent's permission, information with parents or other adults who share responsibility for the patient. Such action is especially useful in helping some adolescents initiate communication with their parents or others in sensitive or difficult areas.

THE PHYSICAL EXAMINATION

The conduct of the general physical examination can have considerable influence on the relationship that forms between the adolescent and the clinician. As adolescents contemplate the prospect of a clinical visit, they develop expectations about what will happen during the session, including impressions and thoughts the clinician might have about them. Because of the ways in which they think about themselves, many adolescents assume that the clinician will be as concerned with, and as impressed by, aspects of their physical appearance and clinical problems as they are.

When the clinician has interviewed the adolescent in an objective, thorough, and responsive manner, the stage is set for the clinician to continue in the same style during the physical examination. Privacy is as important in the physical examination as it is in the interview, and the presence of a parent or other adult is usually inappropriate. The physical examination is conducted with the adolescent wearing underpants and socks, girls being provided with a loose-fitting gown that provides adequate access to the back and chest. The patient who is comfortable during the examination is in a position to raise additional questions and to exchange information and learn as the examination progresses. In this way, the patient continues to be engaged as an active participant in health care. Should the adolescent encounter a clinician who is somewhat apprehensive or uncomfortable in discussing the history or in approaching the physical examination, some of the adolescent's speculation about the clinical visit becomes more real, evidence that the adolescent tends to use the clinician to monitor various impressions. When the clinician approaches an issue that is difficult or serious for the adolescent in a systematic, explanatory