

Review of teenage health: time for a new direction

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SUMMARY. Teenagers represent a large proportion of the population and have the potential for considerable morbidity because of high smoking rates and unwanted teenage pregnancy. The government intends to reduce the incidence of this important morbidity, but there is no coherent strategy for attaining these improvements. Research in this area is limited in the United Kingdom, but research from elsewhere has clarified teenagers' attitudes. There have also been some intervention studies resulting in improvements in specific aspects of teenage health. A worrying theme which emerges from this research is of a new inverse care law. Teenagers with low self-esteem and less hope for their own future are more likely to lead lifestyles which put them at risk and are less likely to ask for advice in relation to their health or lifestyle. Thus, it may be more difficult to alter behaviour in these patients; overall population based improvements may be difficult to achieve. Teenagers' own concerns appear to be at variance with the goals dictated by government and health professionals. It is suggested that the only method of meeting the needs of teenagers and at the same time aiming to reduce morbidity in this age group is to foster an atmosphere of patient centredness in dealings with adolescent patients and for further research in this important health gain area.

Keywords: health services for adolescents; health status; behavioural influences; health promotion; health professional's role; doctor-patient relationship.

Introduction

TEENAGERS are traditionally thought of as being those aged between 13 and 19 years. Different authors have used various subsets in this group and, where possible, this is defined in the text. Teenage health is of sufficient concern for the government to make targets for improvements in its *Health of the nation* document.¹ These targets were to reduce smoking among 11–15 year olds by 33% by 1994, to reduce conceptions by 50% among those aged under 16 years by the year 2000, as well as to reduce suicides, accidents and sexually transmitted diseases in these and other age groups. This article attempts to summarize current knowledge regarding teenage health. It is founded upon the fact that teenagers do not conveniently fit into any of the current medical specialties; therefore attention to their health is particularly relevant to primary care.

In a review published in 1989 Melville argued that teenagers frequently have a hidden agenda behind the apparently physical

symptoms which they bring to the surgery.² This is borne out by other research which suggests that behaviour problems (low mood, school problems, relationship difficulties, and so on) may be present in 10–15% of adolescents.^{3,4} Melville also highlights areas which may lead to sub-optimal care; he describes how consultations with teenagers can become a chance to catch up on late surgeries; good communication may be difficult with brisk and bureaucratic staff; and there may be poor understanding of the special problems, language and sub-cultures of adolescents.²

Bewley and colleagues found that teenagers felt more unwell than could have been inferred from their low consultation rate with general practitioners.⁵ There were several areas of morbidity which had previously been unknown, in particular concerning weight and skin problems. Health concerns identified among teenagers in an inner London suburb included a wish to discuss with an older person, not necessarily their general practitioner, issues of sexuality.⁶ They also showed that a large number of teenagers had unhealthy lifestyles, involving smoking (20%), alcohol (54%) and illicit drug use (6%). These figures are matched by data from other reports.^{7–10}

Malus provides an argument in favour of specialists in adolescent medicine.¹¹ He cites several examples of research and development in the United States of America using specialist services which have resulted in improved teenage health. There has been opposition to this plan,¹² in that it removes teenagers from their social context and might produce difficulties with the interface with other specialists. Furthermore, hospital doctors often attract criticism from teenagers.^{13,14} Nonetheless, Malus discusses a number of useful issues and he argues persuasively that adolescents as a group need a specialist advocate in the same way that geriatricians and paediatricians advocate improvements in care of the elderly and the young, respectively.

The general practitioner, on the other hand, is in an ideal position for personal action because teenage patients are seen on an intermittent basis for routine care. Therefore, the primary care team should be the most easily available to enhance the provision of services for this age group. What do we know about some of the specific health problems of the teenage years?

Smoking

Smoking often starts in adolescence, although there are children aged under 10 years who already smoke.¹⁵ Evidence suggests that teenagers who choose to smoke have certain characteristics: their family and friends frequently smoke; they feel less in control of their lives than non-smokers; they may be rebellious, with low self-esteem, less confidence, and more anxiety; and their leisure time is spent working or 'hanging out'.^{16,17}

Research suggests that recent measures to provide advice regarding smoking in school (as part of the national curriculum) may not be necessary; Macfarlane and colleagues found that a very large proportion of teenagers (98%) already knew of the dangers of smoking.⁹ Recently, a study was conducted to see if school based smoking education is effective in reducing the incidence of smoking in 11–13 year olds.¹⁸ At the end of the two year study there was more knowledge in the intervention groups but the same level of smoking; about 12% of the 13 year olds smoked regularly.

This contrasts with work which suggests that teenagers were

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prepared to listen to smoking advice provided by the primary health care team and were prepared to make an agreement with the practice nurse or doctor to give up smoking.¹⁹ Other work from one practice has suggested a similar trend.²⁰ It remains to be seen whether these interventions will result in long-term cessation.

These results conform to a finding from New Zealand that it is better to give personal health promotion advice because teenagers reported that they will listen if 'they [doctors] make it seem really important'.¹⁴ This contrasted with teachers' advice which was regarded as 'just putting on a record, just a lesson'. Further work suggested that it may be more appropriate to discuss smoking in relation to short-term social gains rather than to focus the discussion on long-term health risks.^{14,21}

However, Macfarlane points out that health professionals should not pretend that their health promotion is going to have more than a small effect in comparison with potent influences like peer group pressure, advertising, imitation of parents, boredom, the need to experiment, and an impression of a 'mature' self image.²²

Nonetheless the apparent successes of one-on-one interventions in general practice suggest smoking habits are worthy of discussion with teenagers if time allows. This is likely to become important in the current climate of health promotion.²³ However, research is needed to determine appropriate timing and methods of intervention.

Sexuality, contraception and pregnancy

Research in the USA shows there has been an increase in teenage sexual experience in recent decades.^{24,25} This has resulted in a dramatic increase in teenage pregnancy. There is evidence that the problem is becoming apparent in the United Kingdom.²⁶

Previous research from the USA shows that many sexually active teenagers had not used contraception for up to one year after becoming sexually active.²⁷ When asked for reasons as to why they had become pregnant, over 50% of pregnant teenagers had thought they could not become pregnant, 25% had thought it was the wrong time of the month, 20% had not anticipated intercourse, 5% had thought themselves too young to become pregnant and only 3% had been lacking in information on contraception. In 1975 Shah and colleagues found that 23% of pregnant teenagers had intended to become pregnant and also that 19% had been using contraception which had evidently failed.²⁸ These figures are matched by more recent reports.²⁹⁻³¹

Teenage sexuality is often spontaneous and may involve intermittent episodes with several partners on an infrequent basis.³² With the human immunodeficiency virus (HIV) as a potential problem teenagers are encouraged to use condoms to prevent its spread. Simplistic interpretation of Finnish data suggests that with advice to use condoms as protection, the use of hormonal contraception falls; there is then the risk that pregnancy rates may rise with the use of less effective contraception.³³

One report shows that although over 90% of adolescent males realized the value of condom use, only 15% used one at all times and 50% hardly ever or never used one.³⁴ More recent data have confirmed only marginally better figures, even with the advent of the HIV virus.^{35,36}

Recent Scottish work has emphasized the importance of socioeconomic factors on teenage pregnancy rates, with higher rates seen in the more deprived areas of one health district and also fewer pregnancies ending in abortion in these areas.³⁷

Four features of adolescence make the provision of contraception difficult for this age group:³²

- adolescents' thought processes seldom include a realistic view of the future;

- adolescents who feel unworthy and unimportant may view conception as an acceptable outcome;
- the 'myth of immunity' sometimes supervenes (as in 'it won't happen to me');
- pregnancy demonstrates independence, but also allows continuing dependency on parents.

Thus, pregnancy is a potential outcome at any time in a relationship between teenagers. From a medical perspective, there are increased risks to mother and fetus in teenage pregnancies (decreased birthweight, increased anaemia, hypertension, greater perinatal risk).^{38,39} Evidence suggests teenagers who become pregnant are less likely to complete school, get qualifications or have a job, leading to financial disadvantage, deprivation and social isolation.^{25,26} Reports suggest that teenage mothers turn to tobacco as something to do while trapped, lonely and isolated.^{40,41} There is a possibility that with social fragmentation the children, as they grow up, will become likely to indulge in behaviour that puts them at risk of teenage pregnancy.^{25,32,42}

It is, however, important to guard against negative professional attitudes. Sorenson found that 24% of pregnant teenagers felt that their decisions about contraception were adversely affected by perceived negative attitudes from the family physician⁴³ although this may be rationalization after the event. A seminar on teenage pregnancy reported a continued perception of these negative attitudes.²⁶

In a review article Lobb cites the success of the Dutch experience with their open, frank discussion of sexuality among teachers and health professionals and specific contraception services for teenagers.⁴⁴ Further evidence of the benefit of this idea comes from the USA where adolescent family planning programmes have resulted in lower teenage pregnancy rates in areas covered by the clinics.^{45,46}

This correlates with a perception among New Zealand teenagers that they would prefer to receive contraceptive services away from their general practice, although they would still visit their general practitioner if necessary. Therefore, 'barriers of time and confidentiality... need to be kept to a minimum between teenagers and health advisers if they are to get the necessary support.'¹⁴ It appears important to ensure services are sufficiently sensitive to teenagers' needs to try to provide contraception among this age group whenever it is required.

Health promotion issues

Little work has been published on the effects of health promotion by the primary care team for adolescents. Unpublished results from a study of notes held by a practice in Cardiff suggest low recording of information in notes of teenage patients. Health promotion may of course occur without recording it in the patient's notes, but work in the same practice suggests that the recording of health advice to adult women is correlated with improved recall of that advice.⁴⁷

Helpful work from New Zealand revealed that teenagers regarded health as being to some extent a person's own responsibility, however those with more fatalistic viewpoints felt less in control of their lives in general, with health being but one of these aspects of poor control.¹⁴ Macfarlane and colleagues found similar responses from Oxford teenagers who answered a questionnaire at school.⁹

This correlates with work showing that those with lower educational success are more likely to smoke,⁴⁸ more likely to indulge in early sexual experience⁴⁹ and more likely to drink alcohol excessively.⁸ It is apparent that those with less hope for their future may be more fatalistic about their future and may be

less likely to seek or want advice, even when they are the ones who may be most at risk; another example of the inverse care law.⁵⁰

New Zealand teenagers reported their readiness to listen to health advice, although they also reported that 'too much health promotion could be an invasion of their medical rights to find out about their own limits'.¹⁴ A similar response emerges in a UK report on the sexual habits of 16–19 year olds,³⁶ the most sexually active were the most 'fed up hearing about HIV'.

The implication is that there is a risk of overkill; too much health promotion may be perceived as nagging and be detrimental to long term objectives for health.⁵¹ How much health promotion is appropriate to this age group must now become a formal research question, especially in view of the new NHS health promotion arrangements requiring information gathering and intervention in patients over the age of 15 years.

Autonomy

The legal age for transformation from child to adult (that is, personal responsibility for health care) is set at 16 years of age in the UK. However, the Gillick verdict on the issue of contraception for those aged under 16 years has changed the climate for this age group.⁵² In this legal test case the law lords decided that girls aged under 16 years could receive contraceptive advice without parental knowledge provided they were considered mature enough to understand the implications of their decision. In the USA mature minors are defined as those who can make their own decisions on daily affairs, are mobile, independent, can manage finances, initiate appointments, and can understand risks, benefits and informed consent.⁵³

In an article on autonomy, Higgs makes several interesting points.⁵⁴ First, the definition of a mature decision is made by an adult (the doctor) and may, to some extent, be defined as mature if the decision the patient makes conforms to the doctor's ideas. This does not apply to decisions made by patients aged 16 years and over, when by definition the patient is adult and all decisions are mature. He goes on to say that it is reasonable for teenage patients to consult on their own as long as the patient and family are happy with this situation, although if there is any doubt the doctor may request the presence of an adult in consultations with minors. He concludes that the 1989 children act has clarified that parents have 'duties and obligations to children, not rights over them', allowing more leeway in decisions on treatment of those aged under 16 years.^{54,55}

Evidence suggests that teenagers begin to make their own decisions on attending for health care at the age of 14 to 15 years. Research from Exeter shows that over 50% of boys, and just under 50% of girls reported seeing their general practitioner on their own at the age of 15 years.⁵⁶ They may choose to be accompanied by a friend rather than a parent. These data are matched by work from one practice suggesting that adult consultation rates begin to emerge at 15 years of age.⁵⁷

Teenager-specific health clinics

One method of providing more sensitive care is to create separate clinics for teenagers. This was first suggested and carried out by Donovan and McCarthy.⁵⁸ They achieved annual rates of attendance of over 50% for the 16 and 17 year olds in a London practice and discovered many unknown problems and missed immunizations. Since then there have been other reports on teenage clinics in primary care settings in the UK.^{19,20} The clinics appear to have been well received by all concerned, health professionals and patients alike.

However, these clinics require further consideration. First, those who do not attend require more intervention, with research suggesting that teenagers with less hope are at greater risk but are less likely to seek advice.^{13,14,17,25,32,36} Secondly, the benefits of clinics require more formal evaluation including the opportunity costs and organizational features.

Teenagers in routine surgery

In the UK it is difficult to obtain data on the incidence of morbidity in this age group which comes to the attention of the doctor because national morbidity statistics are presented in age bands 5–14 years and 15–24 years.⁵⁹ Data from the USA suggest that the most common teenage-initiated consultation topics include upper respiratory tract infections, skin disorders, allergy, contraception and injuries.⁶⁰

A study in one general practice in Cardiff has found important age–sex trends.⁵⁷ Younger teenagers were seen in the surgery infrequently, but at similar rates for both sexes, whereas above the age of 15 years males consult rarely and females consult more often than the practice average.

Little work has been published on consultations with teenagers. A study of consultation times in a Cardiff practice which offers 10 minute appointments showed that all six doctors in the study spent less time in consultations with teenagers than with other patients.⁶¹ The difference was nearly two minutes, a shortfall of 20%. These data are supported by work from Edinburgh involving 21 707 consultations conducted by 85 doctors (Heaney D, University of Edinburgh Department of General Practice, personal communication). There are several possible but unresearched reasons for this finding: the nature of teenagers' presenting problems means that consultations may be short, administrative factors may be important (for example, the surgery may be running late and consultations with teenagers could be used to catch up), the teenagers may prefer this situation, or the doctor may feel that consultations with teenagers do not require broadening to include health promotion and an understanding of the deeper reasons for seeking help.

Teenagers have reported that they often feel uncomfortable with general practitioners.⁶² It is also apparent that they have issues which they would like to discuss.^{5,6,9} It is important to consider how teenagers could feel more comfortable in the surgery, so that health professionals and teenagers can discuss issues in a mutually supportive and helpful atmosphere.⁶³

Conclusion

Teenage health appears to be a further version of the inverse care law; teenagers who are more at risk of teenage pregnancy, smoking and possibly alcohol and drug use are less likely to seek or want advice on their lifestyle. However, the government aims to reduce the incidence of important morbidity for the overall teenage population without adequate research on teenagers' views of the risks. Data suggest that these at-risk patients will prove most difficult to reach and may make reductions more difficult to attain.

There have been some reports of benefits in specific changes to the delivery of care, in particular smoking clinics and teenager specific family planning clinics. However, these data are on a modest scale and require more detailed evaluation.

In general teenagers are healthy and attend the surgery infrequently, often for what appears to be minor illness. Health concerns of teenagers are mainly about their appearance (for example, worries about their skin or their weight). These concerns need to be listened to by doctors if the doctors, in turn, wish teenagers to listen to them about matters such as smoking or contraception.

We suggest that there should be a rethink of how to tailor the existing primary care framework to be more teenager friendly. This should allow for the needs of teenagers to be taken seriously. It will be founded on a national need to reduce teenage pregnancy and smoking and ensure improved health for this age group. However, since teenage patients may not make their needs explicit, it is suggested that the only way to achieve these benefits is to foster an atmosphere of patient-centredness in clinical dealings with teenage patients and in the organization of services.

Doing this may, however, lead to some surprises as the teenage voice does not always carry a plea for conventional help from adults in society: a teenager who attended a conference to discuss issues of teenage health said:

'The kids where I live don't give a xxxx about their parents or anybody or anything. Your generation messed up the country... Stop trying to improve other people and improve yourselves.'⁶⁴

New directions

The authors suggest the need for the following research to be carried out for teenagers:

- the presentation of health promotion messages, regarding drug use, smoking and lifestyle;
- innovative and patient-centred methods to reduce rising teenage pregnancy rates;
- methods to improve communication between doctor and teenage patient; and
- evaluation of alternative methods of health care delivery within primary care.

The teenagers of today will become the adults and parents of tomorrow. Could well directed research efforts help to promote better health for future generations? Could a change in adult attitudes modify the teenage inverse care law? Or is hazardous teenage rebellion a requirement for social development?

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