

Essay

Geriatric paediatrics: reflections on models of adolescent health



The tortuous ascent up muddy footpaths, through dense foliage, and amidst buzzing insects exhausted me, but nonetheless constituted the daily commute for youth who resided in the mountain-top village on Mfangano Island, Kenya. I had travelled to the azure shores of Lake Victoria to conduct research on nutrition support for young people living with HIV. In this community, patients followed paediatric protocols until abruptly changing to adult care on their 15th birthday. Overnight, the medical system suddenly expected these teenagers to become adults and make medical decisions on their own. Older adolescents in Kenya did often acquire adult social roles and responsibilities, including working on the farms and raising children. However, left to their own devices, many teenagers neglected their regular medical care. I remember "Otieno", a 17-year-old whose stalwart build from months of construction work and farm labour masked the reality of his skyrocketing viral loads resulting from sporadic adherence to his antiretroviral therapy. His mother had established and supervised his HIV care since his birth while he lived with her in the Kenyan mainland. When he moved to Mfangano Island to work on his uncle's farm at age 16, he never established his HIV care, focusing only on his daily labour and income. His adherence to antiretroviral therapy became infrequent as he only received medications at his parents' request on the occasions when he returned to the mainland.

Clinic health workers recounted similar stories of teenagers who had fared well on the paediatric protocols with parental supervision, but who disappeared from care once they became so-called adults. This highlighted for me the importance of transitions in care, especially for vulnerable adolescents living with HIV. Certainly, this rural Kenyan setting had limited resources, but I contemplated what models might facilitate the transition from paediatric to adult care during adolescence in other settings.

Reflecting on the medical care I received during my teenage years growing up in Los Angeles (CA, USA), I transitioned from my paediatrician to a family medicine physician when I turned 18. Dr Ron provided primary care for both of my parents, and the continuity of care created a strong bond between Dr Ron and our family. I even shadowed him a few years later when I was a medical student. However, geriatrics constituted the majority of his practice, and the general clinic lacked focus on the common health issues affecting teenagers. Consequently, I never felt comfortable disclosing my sexual orientation or other confidential issues, especially given his close relationship with my parents. I might have been more comfortable sharing this information in an

adolescent-specific clinical setting that I perceived to be more separated from my parents' care.

I discovered a prime example of adolescent-focused care when I rotated through my university's Teen Clinic during medical school. Posters with information on mental health resources, sexually transmitted infection screening, and contraception plastered the walls of each clinic room. Rainbow borders enveloped providers' name badges to demonstrate support for sexual and gender minorities. However, age restrictions limited the patient population we could serve. We cared for patients only until their 26th birthday. For this reason, we developed a transition plan to adult care well before patients' 26th birthdays, especially for patients with special health-care needs. For instance, "Sabrina", a young woman with anorexia nervosa whose lavender eyeliner and fuchsia highlights could not obscure her emaciated figure. She had struggled with restrictive eating for more than a decade. She fasted for days on end and required monthly hospital admissions because of unstably low heart rates. When she turned 26, I wondered how she would fare without the adolescent-focused services, including our school programme to help with accommodation for her four college courses and art therapist who elicited her eating disorder thoughts via expressive watercolours of foods and gloomy self-portrait sketches in her hospital room. I wondered if she would be better served continuing with the close relationships she

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Health centre on Mfangano Island, Kenya

had developed with medical, mental health, and nutrition providers tailored to her developmental age. While our age-eligible patients appreciated that we had dedicated clinic space and providers for adolescents and young adults, in some ways our model remained quite vertical and rigid for patients like Sabrina.

As I furthered my medical training through paediatric residency, I searched for other models of adolescent health care globally and found the opportunity to participate in an international rotation with Dr Patricia, a physician who staffed an adolescent-focused clinic in Riobamba, Ecuador. The Ecuadorian Ministry of Public Health invested in adolescent-focused health-care services and dedicated an entire wing of the community health centre, facing the snow-capped volcano Chimborazo, to the health of adolescents. On my first day in Ecuador, I encountered "Maria", a 16-year-old mother with newborn twins who entered the clinic carrying one infant in each arm. Dr Patricia reviewed all aspects of Maria's postpartum health and discussed prevention of additional pregnancies, offering to place a contraceptive implant. The Ministry of Public Health prioritised the prevention of teen pregnancies and provided long-acting reproductive contraception at no cost to teenagers. Dr Patricia noted, however, that sometimes the supply would run out for months at a time, so it was important that Maria receive her implant soon, as she could not guarantee they would be available the next month. She also performed newborn well child checks on Maria's twins, assessing their flaky yet delicate skin for jaundice, auscultating their diminutive hearts for murmurs, and inspecting their umbilical stumps for signs of infection. She provided Maria with candid and practical parenting advice, providing tips to optimise breastfeeding, showing how to soothe a crying baby, and demonstrating proper sleep positioning. This clinic retained an adolescent-specific focus but also maintained the longitudinal continuity of the general practitioner care model.

Although the vast majority of patients in the clinic were teenagers, Dr Patricia never turned away patients, regardless of their age. Anyone who endured the long queue along the dusky wooden entrance of the adolescent health clinic would be seen, even though there

were neighbouring adult and paediatric clinics within the same health centre. Dr Patricia taught me to appreciate the role of adolescence through the entire life course. She jokingly referred to adolescent medicine as "geriatric paediatrics". She understood that intervening on a 6-month-old infant's downward spiral of plummeting growth, parasitic diarrhoea, and chronic cough allowed her to survive through infancy so that she could thrive in adolescence. Similarly, when "Señor Pablo" stumbled into the clinic reeking of whisky and stale urine, Dr Patricia explained that his alcoholism and smoking dependence developed decades earlier after he was orphaned as a teenager. Although the clinic was focused on adolescents, Dr Patricia happily followed up patients as they aged into adulthood and even cared for their children and other family members. This model of care uniquely valued the relationship of adolescence to the rest of the life course.

My experiences in Kenya, the USA, and Ecuador demonstrated different models for providing care for adolescents. In Kenya, I learned about the importance of transitions of care from paediatrics to adult medicine. From my own experience in the USA, I understood the value of adolescent-focused care. Because of my rotation in Ecuador, I now view adolescence across the life course and think less about strict age cutoffs and more about social roles and responsibilities as they affect young people. Although adolescent-focused clinics can ease the transition from paediatric to adult care, I appreciate the benefit of integrating flexibility into the transition plan. Although it might be appropriate to advance the majority of patients along a set timeline for transitions of care, some patients may benefit from adolescent-focused or young-adult-focused care longer than others. Allowing these patients to benefit from the resources of the clinic may improve the overall trajectory of their health over the life course. Despite limited resources, physicians like Dr Patricia were able to provide adolescent-focused holistic care across the life course, and her example inspired me to continue to advocate for the health of young people. I will have my work cut out for me in the field of "geriatric paediatrics".

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