

## Special Article

# Medical Curricula Development for Adolescent Medicine in the United States: What Have We Learned and Where Do We Need To Go?

CE IRWIN, JR

### Abstract

The development of the medical curricula for students in medical school, residents in primary care specialties and subspecialty training in Adolescent Medicine has been an evolving process over the past fifty years in the United States (U.S.). This paper highlights the historical trends with a special emphasis on what has been learned in the development of Adolescent Medicine curricula in subspecialty fellowship training and pediatric programs. The Medical System within the U.S. has acknowledged Adolescent Medicine as a special area for over fifty years with the establishment of special clinical delivery programs for adolescents and young adults. In the late 1960's, the Society for Adolescent Medicine (SAM) was formed to promote the development, synthesis and dissemination of scientific and scholarly information unique to the development and health care of adolescents. In the 1970's, the professional organizations in Pediatrics embraced the concept of Adolescent Medicine with the establishment of subspecialty sections within the American Academy of Pediatrics and the Pediatric Academic Societies. In 1979, the Task Force on Pediatrics recommended that educational programs in Pediatrics should increase their emphasis on adolescent health. With this recommendation, the pediatric residency training requirements began to evolve to include Adolescent Medicine as a special emphasis area with the eventual establishment of a one-month requirement for residency education in the mid 1990's. Family Practice and Internal Medicine residency programs now include Adolescent Medicine as a special area with no designated time requirement. Concurrently, the subspecialty certification process for Adolescent Medicine emerged within the American Boards of Pediatrics and Internal Medicine, the certifying bodies for specialization for these primary care specialties. In 2002, Family Practice joined with the two other primary care specialties to offer subspecialty training in Adolescent Medicine. Over the past decade, there has been a gradual movement within medical education to increase the content of education related to life-span development. This emphasis has enabled Adolescent Medicine to be more fully integrated into the medical curriculum during the first two years of medical education.

### Key words

Adolescence; Adolescent medicine; Medical school education; Pediatrics; Training

Division of Adolescent Medicine, Department of Pediatrics,  
School of Medicine, University of California, San Francisco,  
3333 California Street, Suite 245, San Francisco, CA 94118,  
U.S.A.

CE IRWIN, JR

MD

Correspondence to: Prof CE IRWIN, JR

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### Introduction

The development of the medical curricula for students in medical school, residents in primary care specialties and subspecialty training in Adolescent Medicine has been an evolving process over the past fifty years in the United States (U.S.). This paper highlights the historical trends in the field of Adolescent Medicine with a special focus on what has been learned in the development of curricula in subspecialty fellowship training and pediatric programs. The experiences

over this time period may prove useful to other countries as they begin to develop curricula for training medical students, residents in primary care training and subspecialty fellows.

## Historical Context of the Field of Adolescent Medicine

Fifty-one years ago, an Editorial in the *New England Journal of Medicine* commented on the birth of a new field in Medicine – Adolescent Medicine. The editorial stated: "A neglected field of medicine has been that of adolescence: the explanation is simple. Until recently, the pediatrician has been preoccupied with premature babies, transfusion problems, running ears.... The internist has also been busy with the ills of adulthood and has still to come to the period of adolescence. Yet this field is particularly important because it marks the transition from boy to man and girl to woman."<sup>1</sup>

Table 1 highlights the seminal events in the field of Adolescent Medicine in the U.S. Even though, the American Academy of Pediatrics (AAP) in a policy statement in 1938 had planted the first formal seed and included the term "adolescence" in its policy statement on the practice of Pediatrics; the seed had scarcely begun to germinate by as

late as 1952 when Dr. J. Roswell Gallagher opened the first Adolescent Clinic at the Boston Children's Hospital in Massachusetts.<sup>2</sup> Over the next fifteen years from 1953 to 1965, a small number of adolescent clinics emerged at academic medical centers. As these clinical operations expanded, a series of conferences sponsored by the federal Maternal and Child Health Bureau, Department of Health and Human Services conferences were initiated in 1965 for the purpose of encouraging discussion of the common issues that the clinicians were confronting in caring for adolescents. In 1967, the federal government recognized the importance of training physicians following their primary care training and began to support fellowship training in Adolescent Medicine for 14 fellows in 7 cities throughout the U.S. By 1968, a small cadre of physicians joined together to form the Society for Adolescent Medicine (SAM). SAM was established primarily by academic based physicians to provide a forum for information, exchange and collegiality.<sup>3</sup> During the 1970's, a flurry of activity brought Adolescent Medicine into the mainstream of Pediatrics. In 1972, the AAP stated: "The purview of Pediatrics.... begins in the period prior to birth when conception is apparent. It continues through childhood and adolescence when the growth and developmental processes are generally completed."<sup>4</sup> The American Medical Association (AMA) recognized the emergence of this new

**Table 1** Seminal events in the field of Adolescent Medicine

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<b>1938:</b>	Policy Statement, American Academy of Pediatrics
<b>1951:</b>	First Adolescent Clinic, Boston, Massachusetts
<b>1967:</b>	Fellowship training in Adolescent Medicine initiated
<b>1968:</b>	Society for Adolescent Medicine founded
<b>1977:</b>	Adolescent Medicine specialty definition, American Medical Association
<b>1978:</b>	Task Force Report on Pediatric Education
<b>1980:</b>	<i>Journal of Adolescent Health Care</i> first published ( <i>Journal of Adolescent Health</i> as of 1990)
<b>1984:</b>	Assessment of Pediatric Departments, U.S. Medical Schools
<b>1986:</b>	Carnegie Council on Adolescence
<b>1991:</b>	<i>Adolescent Health Report</i> from U.S. Congress, Recommendations: Improving adolescents' access to health services; Restructuring and invigorating federal efforts to improve adolescent health; Improving adolescents' environments
<b>1992:</b>	Clinical Preventive Service Guidelines developed for Adolescents, AMA, MCHB & AAP
<b>1994:</b>	First Subspecialty Examination by American Boards of Pediatrics and Internal Medicine
<b>1996:</b>	Fellowship Training: 39 programs in U.S. & Canada Residency Training: Pediatrics: required for 2 out of 33 months Internal Medicine and Family Practice: no specific requirement
<b>1997:</b>	WWW Access to national data sets
<b>2000:</b>	Family Practice offers subspecialty certification with Pediatrics and Internal Medicine Residency Training
<b>2002:</b>	Pediatrics: requires 2 out of 33 months (same as 1996) Internal Medicine: adolescent medicine should be included in core educational conferences Family Practice: clinical exposure to adolescents as part of pediatric experience (4 months)
<b>2003:</b>	<i>U.S. Teens in Our World</i> (HRSA)
<b>2004:</b>	26 ACGME accredited fellowship training programs

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field in 1977 by confirming that Adolescent Medicine met the AMA's established criteria for specialty definition. The following year (1978), the recommendations of the Task Force on Pediatric Education were published.<sup>5</sup> This Task Force Report highlighted the critical importance of adolescence and the need to include the health issues of adolescents in the core content of pediatric education. The Task Force Report stated: "The health needs of adolescents are being inadequately met. Pediatrics should now take upon itself the full responsibility for improving health care and research for this segment of the population."<sup>6</sup> In a survey done for the Task Force deliberations, 66% of the recent graduates of pediatric residency programs continued to feel inadequately trained in Adolescent Medicine.<sup>5</sup> In a move to intensify its commitment to providing continuing education in Adolescent Medicine for practicing pediatricians, the AAP established the Section on Adolescent Health in 1978. During the 1980's, the field continued to mature with the establishment of an official Journal sponsored by SAM, *Journal of Adolescent Health Care* (now known as the *Journal of Adolescent Health*), several textbooks in the field were published and a dialogue was initiated among the Society for Adolescent Medicine and the American Boards of Pediatrics, Internal Medicine and Family Practice concerning subspecialty certification in the field of Adolescent Medicine. With the multitude of changes that had occurred in the field over the past two decades, SAM redefined its purpose in 1989 – "The major focus of SAM is to promote the development, synthesis and dissemination of scientific and scholarly knowledge unique to the development and health needs of adolescents."<sup>2</sup> During the 1990's, there was a major coming together of several sectors of society in the U.S.: private foundations began to pay attention to adolescents, the professional medical organizations demonstrated concern about their members expertise in caring for teenagers, certifying organizations embraced Adolescent Medicine with subspecialty certification and the federal government issued a major report. These activities culminated in three major events of the 1990's: the publication of a three volume report on Adolescent Health by the Office of Technology Assessment (OTA);<sup>7</sup> the development of a subspecialty examination and certification process for pediatricians and internists who have special expertise in the field of Adolescent Medicine and the development of guidelines for Clinical Preventive Services.<sup>8,9</sup> The recommendations from this report to the U.S. Congress emphasized the need to improve adolescents access to health services, restructure and invigorate the federal government's efforts to improve adolescent health improve adolescents' environments. By 1992, the American Boards of Pediatrics and Internal

Medicine with the approval of the Accreditation Council for Graduate Medical Education (ACGME) began the process of specialty certification examinations for pediatricians and internists. In 1994, the first certifying examination was given in Adolescent Medicine to 465 examinees (388 Pediatricians and 77 Internists). Of these 465 first time takers, 381 passed the examination.<sup>10</sup> Since 1994, the examination is given every two years. In 2002, the American Board of Family Practice joined with the American Boards of Internal Medicine and Pediatrics to offer subspecialty certification in the field of Adolescent Medicine. With the establishment of specialty certification in Adolescent Medicine, all training programs in which the training leads to certification must be approved by ACGME. With this requirement, there are now 26 training programs in Adolescent Medicine, which is down from a peak of 39 programs in 1996.<sup>11</sup> One of the most critical changes in training of general pediatricians occurred in 1996 when the ACGME requirements for residency training in pediatrics officially enacted a core requirement in Adolescent Medicine for Pediatrics.<sup>11</sup> In the late 1990's, we saw an unprecedented explosion of national data sets documenting trends in utilization of services, risk behaviors and health status.<sup>12</sup> These data are easily accessible through the Internet. By 2000, Internal Medicine and Family Practice added exposure to Adolescent Medicine but no formal requirements. As we have entered the 21st century, there is more interest in thinking about the global health issues of adolescents through comparing and contrasting differences throughout the world.<sup>13,14</sup> This global interest in Adolescent Medicine and Health is supported through the International Association of Adolescent Health (IAAH).<sup>15</sup>

## Documentation of Special Status of Field

Prior to initiating the process for specialized training in Adolescent Medicine, the ACGME requires documentation of the special status of the field. The documentation includes the existence of a body of scientific knowledge demonstrating the unique nature of the health problems of adolescents, the existence of a group of physicians focusing on adolescents in their clinical practices, the existence of national societies committed to the field of Adolescent Medicine and the existence of fellowship training programs in Adolescent Medicine.

A sizeable body of scientific knowledge exists about Adolescent Medicine and adolescence.<sup>16,17</sup> Adolescence itself is clearly acknowledged as a unique developmental period with unique health problems often complicated by social/psychological and environmental changes and

problems. The interactions among biologic, psychological and social forces are especially important in relationship to adolescent health problems and practice. The documentation of the special status of the field is best portrayed by the number of journals and textbooks focused exclusively on adolescence (see Tables 2 & 3) and the inclusion of special sections in the major Pediatric and Internal Medicine textbooks (see Table 4).

As stated in the previous section on historical context of the Field, since 1938 there was a continuous movement to include adolescents within the field of Pediatrics. From 1968 through the present, there has been a much stronger commitment within professional organizations, certifying organizations and the public and private sectors to focus on the critical importance of adolescence as a period that is not only important for improving the health of young people but setting the stage for improving the health status of adults.<sup>16</sup> In January 1991 when the American Board of Pediatrics began the process of petitioning the ACGME to

establish formal certification for Adolescent Medicine, there were 39 fellowship-training programs in the U.S. In 1991, there was no specific curriculum for training in the field of Adolescent Medicine. In the late 1970's, SAM's education committee developed a curriculum.<sup>18</sup> This curriculum was available to training programs, however, each program in the U.S. did not have to adhere to any specific guidelines prior to the development of the subspecialty certification process.

## What Have We Learned?

### ***Fellowship Training in the United States: from Inception to Certification***

Fellowship training in the United States began in the late 1950's at The Children's Hospital in Boston, Massachusetts. The fellowship-training program was a hospital-based program lasting one year following completion of training in either Pediatrics or Internal Medicine. In 1967, the federal government initiated its support of fellowship training sponsored by the Maternal and Child Health Bureau, Department of Health and Human Services (MCHB) at seven academic centers. In 1977, MCHB recognized that caring for adolescents required an interdisciplinary approach which lead to expanding their physician-only training programs to the exclusive funding of institutions that were capable of providing training to health professional trainees in five disciplines (Medicine, Nursing, Social Work, Psychology, and Nutrition). MCHB has continued its focus to the present day and currently there are 7 federally funded LEAH (Leadership Education in Adolescent Health) programs in the U.S. Prior to Adolescent Medicine becoming a board-certified specialty in the United States, there were 39 fellowship-training programs in the U.S. These fellowship-training programs were two years in duration and focused primarily on clinical training with the exception of the MCHB-funded programs, which had a stronger focus on research training. With the onset of ACGME certifying fellowship programs in 1996, there are currently 26 ACGME programs in the United States. In order to sit for the certification examination, a fellow must complete an ACGME-certified program.

The certifying process in Adolescent Medicine allowed for clarity in the fellowship training process. The purpose of certification in Adolescent Medicine is to improve the quality of patient care during the second decade of life, expand and improve training in primary care to include a comprehensive and scientifically based approach to the care of young people as they enter adulthood, stimulate faculty development and improve the quality of research for the

**Table 2** Journals focused on Adolescent Medicine and Health (and year initiated)

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<i>Adolescence</i> (1965)
<i>Youth and Society</i> (1970)
<i>Journal of Youth and Adolescence</i> (1971)
<i>Journal of Pediatrics</i> – Adolescent Medicine specialist, editorial board since 1974
<i>Journal of Adolescence</i> (1978)
<i>Journal of Adolescent Health</i> (1980)*
<i>Journal of Early Adolescence</i> (1980)
<i>Journal of Adolescent Research</i> (1988)
<i>Journal of Research on Adolescence</i> (1991)

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\* initially called the *Journal of Adolescent Health Care* until 1990

**Table 3** Textbooks (Adolescent-specific):

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<i>The Hospitalized Adolescent</i> , Hofmann, 1976
<i>Adolescent Medicine</i> , Hofmann & Greydanus, 3rd. Ed. 1997
<i>Comprehensive Adolescent Health Care</i> , Friedman et al., 2nd Ed., 1998
<i>Adolescent Health Care</i> , Neinstein, 4th Ed., 2002

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**Table 4** General Medical Texts (with Adolescent Medicine Section):

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<i>Rudolph's Pediatrics</i> , 1987 to present
<i>Nelson's Textbook of Pediatrics</i> , 1987 to present
<i>Cecil's Textbook of Medicine</i> , 1988 to present
<i>Harrison's Textbook of Medicine</i> , 1989 to present

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problems of the adolescent population.<sup>10</sup> Programs in Adolescent Medicine must provide training in and include an appropriate balance among clinical, didactic and research activities. The education must include exposure to the broad and diverse knowledge base of the multidisciplinary field that focuses on the unique physical, psychological, and social characteristics of adolescents, their health-care problems and needs. Given that adolescence links childhood with adulthood and usually covers the period beginning with puberty and ends with early adulthood, programs must integrate the relevant areas of pediatrics and the pediatric subspecialties with family practice, internal medicine, dermatology and surgery. Related fields that are critical for training include clinical pharmacology/toxicology, law, psychology, social work, education, nutrition, juvenile justice, sociology and public health. Given the breadth of the field, there must be appropriate physician and nonphysician faculty. Beyond the traditional pediatric subspecialists, there must be faculty in the following areas available as consultant faculty: child/adolescent psychiatry, child neurology, obstetrics/gynecology, general surgery, orthopedic surgery, sports medicine and dermatology. For full implementation of a program, there should be faculty from the following areas available: Psychology, Social Work, School System Personnel, Education, Public Health,

Chemical Dependency, Nutrition and Clinical Pharmacology.

The Facilities and Training Sites are outlined in Table 5. The curriculum includes four broad areas: (1) Core Knowledge Areas as outlined in Table 6; (2) Clinical and Continuity Experience; (3) Didactic Sessions and (4) Administrative Instruction. The Clinical and Continuity experience must provide on site clinical supervision of the fellow in a manner that allows each fellow to assume graded

**Table 5** Facilities and Training Sites

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An inpatient medical service
An outpatient service
Clinical consultation
Additional Clinical settings should include:
College health center
Community health center
Crisis center
Summer camp
Family planning program
Juvenile justice
Mental health center
School-based clinic
Substance abuse treatment program

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**Table 6** Core Curriculum Knowledge Areas

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Physical, physiologic & psychosocial changes associated with pubertal maturation and its disorders
Organ specific conditions encountered during adolescence/young adulthood
Effects of adolescence on preexisting conditions
Mental health disorders
Family dynamics, conflicts & problems
Adolescent parenthood
Disorders of cognition, learning, attention & education
Social & emotional development of the adolescent (including cultural/ethnic diversity)
Chronic handicapping conditions
Disorders of endocrine system & metabolism
Sexuality (including sexual identity, development & sexual health problems)
STIs (prevention & treatment)
Reproductive health issues of males & females
Nutrition
Health promotion, disease prevention, screening & immunizations
Infectious diseases (including epidemiology, microbiology & treatment)
Pharmacology & toxicity
Substance use & abuse (including tobacco & alcohol)
Eating disorders including obesity, anorexia & bulimia
Social & environmental morbidities (including physical & sexual abuse, risk-taking behaviors, injuries & violence)
Juvenile Justice
Sports Medicine
Legal & ethical issues including advocacy
Interviewing & short-term counseling skills for teens & their parents
Public health issues including demographics, social epidemiology, population-based interventions & adolescent health promotion
Financing adolescent health care in public, private & academic environments

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responsibility for both the provision of clinical services and the supervision of other learners during the years of training. The fellow must have experience in caring for both acute and chronic health problems of adolescents in both inpatient and outpatient settings. Each fellow must have the opportunity to provide direct and consultative care to a broad range of adolescents in a variety of hospital and community-based settings. Adolescent medicine fellows must have an outpatient continuity experience for at least 1/2 day per week in an Adolescent Medicine setting for the entire duration of his/her training. Didactic sessions for the fellows must emphasize the core knowledge areas outlined in Table 6. Clinical conferences must include discussion of the basic clinical sciences, health education, current health care policies, biomedical ethics and preventive medicine. Interdisciplinary management needs to be emphasized in training. Administrative instruction must be taught through formal sessions on the organization and leadership of a comprehensive health care team. The fellow needs to get instruction and experience in the knowledge of staffing, program development and management, quality

improvement, financing of health care services, and grant proposal development. The duration of fellowship training for fellows in Adolescent Medicine varies by primary care specialty. For Internal Medicine and Family Practice specialists, there is a two-year fellowship requirement and for Pediatrics there is a three-year fellowship requirement. The Adolescent Medicine Examination Committee determines the content of the examination, which is a joint committee of the three certifying organizations (The American Board of Family Practice, The American Board of Internal Medicine and The American Board of Pediatrics) The Adolescent Medicine Content Outline is listed in Table 7. The complete content specific outline is available through The American Board of Pediatrics web site.<sup>19</sup>

#### ***Fellowship Training: 10 Years after Certification Achieved***

The certification process in Adolescent Medicine has brought Adolescent Medicine into the mainstream of academic medicine with active representation on the key academic committees in pediatrics including the Council

**Table 7** Adolescent Medicine Content Outline

<b>Content Outline for Maintenance of Certification, Subboard of Adolescent Medicine, Examination Percentage List</b>	
HEENT	2%
Cardiovascular	2%
Pulmonology	2%
Physical Growth & Development	6%
Endocrine & Metabolism	7%
Musculoskeletal Diseases	3%
Allergy, Immunology & Rheumatology	3%
Hematology/Oncology	4%
Neurology	2%
Mental health	6%
Cognition, Social/Emotional Development & Family/Chronic Illness	5%
Renal	3%
Reproductive -	
Female	7%
Male	4%
Sexuality	5%
Sexually Transmitted Diseases/AIDS	8%
Gastrointestinal	4%
Nutrition & Eating Disorders	5%
Infectious Diseases	4%
Dermatology	4%
Substance Abuse	5%
Pharmacology & Toxicology	2%
Prevention/Screening	3%
Research & Statistics	2%
Health Services, Ethics & Legal Issues	2%

on Pediatric Education, Council on Pediatric Research and representation on the PAS council for planning the annual academic pediatric meetings. At the same time that Adolescent Medicine achieved certification, there have been a number of converging forces within the U.S. that have influenced the number of individuals choosing to train in cognitive-based fields in Medicine. Primary care residents graduating from medical school and finishing their residencies have a large debt burden. The choice of cognitive-based specialties (e.g., Rheumatology, Nephrology, Behavioral Pediatrics) has been on the decline in Pediatrics without a parallel decrease in procedure-oriented subspecialties (e.g., Cardiology, Neonatology, Emergency Medicine, Critical Care Medicine). One assumption is that the choice of additional training in cognitive-based specialties does not guarantee increased remuneration as compared with the procedure-oriented subspecialties. Beyond the financial considerations, the 1990s were dominated by a major emphasis on primary care within American Medicine. This national policy led to a decrease in the number of residents choosing subspecialty training.<sup>19</sup>

Currently, there are only 74 physicians in training in the United States in ACGME Approved Fellowship Programs.<sup>19</sup> Since the certification process began in 1994, we have certified approximately 700 physicians in the field. These numbers do not bode well for the future: we need to recruit a new cadre of physicians into the field of Adolescent Medicine to maintain the integrity of our educational programs in the U.S.

### **Residency Training**

Even though postdoctoral fellows may enter Adolescent Medicine from the three primary care specialties: Family Practice, Internal Medicine and Pediatrics, there are only specific residency requirements for Pediatrics. Please see Table 8 for Residency Requirements for Primary Care Specialists.<sup>11</sup> The ACGME requirement for Internal Medicine is that there should be content exposure and for Family Practice, there is a recommendation that within the pediatric-component of their training, there should be experience with adolescent patients. In 1996, 18 years after the Task Force Report on Pediatrics,<sup>5</sup> the ACGME requirements for Adolescent Medicine in Pediatrics were adopted. These requirements include a one-month block rotation to ensure a focused experience in Adolescent Medicine. Each residency program must also provide an integrated experience that incorporates adolescent issues into ambulatory and inpatient experiences throughout the three years of training. The core content of training must include those areas outlined in Table 9. Most residency

programs in Pediatrics include University/Medical Center based activities that focus on complex medical problems of youth and Community based experiences that often include exposure to School settings, Family planning clinics, Mental Health programs with a focus on Substance Abuse and College/University Health.

### **Medical School Training**

There is no defined curriculum for medical students in Adolescent Medicine in the United States. The emphasis on the adolescent age group may come through disease or problem-specific lectures (e.g., mental health disorders, endocrinology, dermatology, obstetrics/gynecology, reproductive health, growth and development, etc.); clinical rotations (e.g., pediatrics, obstetrics/gynecology, family practice, etc.) or community-based experiences (e.g., Substance Abuse Treatment programs, family planning clinics, youth serving agencies, etc.).

Over the past decade there has been a growing trend in the United States to revamp medical education in which problem-based learning is emphasized. One of the examples of this approach is at the University of California, San Francisco in which they have developed a "Life Cycle Course" to familiarize medical students with the health problems that occur from conception to death (see UCSF website).<sup>20</sup> This 12-week lifecycle course is taught during

**Table 8** Residency requirements for Primary Care Specialists

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Pediatrics: 1-2 months with designated curriculum
Internal Medicine: should include adolescent medicine in core educational conferences
Family Practice: clinical exposure to adolescents as part of pediatric experience (4 months)

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**Table 9** Core content for Pediatric Residents

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Normal pubertal growth & development
Health promotion, disease prevention & anticipatory guidance
Common adolescent health problems (including chronic illness, sports-related issues, motor vehicle safety & effects of violence in conflict resolution)
Interviewing the adolescent patient with (special emphasis on confidentiality, consent and cultural background)
Psychosocial issues (e.g., peer and family relations, depression, eating disorders, substance use, suicide and school performance)
Male & female reproductive health (including sexuality, pregnancy, contraception and STIs)

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the second year of medical school and has 7 units: Conception and contraception; pregnancy, birth and postpartum; infancy, childhood, adolescence, early and middle adulthood and late adulthood. The Adolescence section is organized and taught by Adolescent Medicine faculty with ten hours of lecture and nine hours of small group seminars. The content focuses on growth and development including puberty and psychosocial development, chronic disease and sports-related injuries.

### Where Do We Go from Here?

Even though the field of Adolescent Medicine has been relatively well established in the United States for over three decades, there remains considerable work to be done to bring the benefits of our knowledge about adolescence to the health professionals caring for adolescents and adolescents themselves. There needs to be a commitment on three levels:

*Commitment to Developing a Cohort of Young Health Professionals:* As I stated in my presidential address to SAM in 2002,<sup>21</sup> "...we have done a great job in creating the structure in medicine for training the next cohort of health professionals but we have done a poor job in attracting the next cohort into the field of Adolescent Medicine." In the U.S., Adolescent Medicine, unlike other subspecialties is a core part of the required curriculum in Pediatrics residency programs, yet this has not translated into an increased number of pediatric residents entering the field. We need to renew our efforts to recruit primary care specialists to focus in the area of Adolescent Medicine. The training model developed in the United States for fellows may not be appropriate for other countries. Each country or region needs to draw upon its unique strengths and decide what is the best route to pursue for specialized training.

*Commitment to Developing Training Curriculum for Other Health Professionals Beyond Medicine:* Caring for adolescents requires an Interdisciplinary perspective, yet most of the curricula that have been developed focus on the medical issues associated with adolescents. Given that there has been an explosion of new knowledge in a number of fields that impact adolescents, there is a need to develop curricula that can be used in training a diverse group of disciplines from different cultures. The curriculum developed by the group in Lucerne, Switzerland called European Training in Effective Adolescent Care and Health ([www.euteach.com](http://www.euteach.com)) may serve as a template for initiating training.<sup>22</sup> Countries throughout the world need to be looking at this curriculum and identifying ways that the

curriculum may be altered to be appropriate for their own professionals.

*Commitment to Continuing Medical and Health Education for Health Professionals:* Currently, there is a large cohort of existing medical and health professionals who are caring for adolescents in their clinical, educational and public health settings. We need to capitalize on this existing manpower and bring our curricula to them. The curricula need to be sensitive to the settings in which they practice and the distinct needs of the diverse groups of adolescents that are served in their respective communities and settings. We need a plan to engage this large cohort of professionals and build upon their knowledge base.

*Content of Training:* Throughout the world we have developed curricula that are unique to our own groups, yet most of these curricula have never been shared with other groups or regions. In an era of limited resources, we can benefit from our collective experiences. As we adapt and build these curricula, we need to remember that adolescents and young adults want to be heard. Our youth want to be engaged in educating our health professionals about their unique needs. As we listen to our youth, our focus remains on the public health issues that lead to improvement of the overall health status of the population. Community-based sites must be expanded in all our curricula to assure that youth representing different perspectives will enrich the training process.

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