Adolescent Medicine Curriculum at Faculty of Medicine, Universiti Teknologi MARA, Malaysia

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ABSTRACT

This article, using the example of the development of an Adolescent Medicine curriculum, highlights the challenges that academicians face and the roles that stakeholders play in the development of medical curricula. To develop the curriculum, apart from using a number of resources, the authors conducted a symposium that was attended by some of the stakeholders. Learning outcomes were identified and the criteria for selection of the content of the curriculum were developed. The teaching/learning methods were recognised and the assessment strategies were formulated. The students felt that this course helped them in: (a) communicating with adolescents, (b) performing examination of adolescent patients, and (c) understanding adolescents’ views on different psychosocial issues. In this paper, the authors summarise the reasons that convinced the faculty to include Adolescent Medicine in its undergraduate teaching programme. The authors also describe the role that different stakeholders played and what further can be achieved by their involvement in such exercises.

Keywords: Adolescent Medicine, Core Topics, Learning Outcomes, Medical Curricula, Roles of Stakeholders

INTRODUCTION

Faculty of Medicine (FoM), Universiti Teknologi MARA (UiTM), Malaysia, was established in December 2002 and enrolled its first batch of students in May 2003. The Faculty decided to adopt a hybrid Problem-based Learning curriculum since its inception. By using innovative approaches in addressing the modern day issues in medicine the Faculty developed its very own curriculum which apart from areas such as Urban Health and Molecular Medicine also addressed Adolescent Medicine.

The 5-year MBBS course is planned into pre-clinical years (years 1 & 2) and clinical years (years 3, 4 & 5). Each of the clinical years is divided into discipline-based postings such as Paediatric Medicine and Orthopaedic postings.

In this article, following the six steps of curriculum development proposed by Kern, Thomas, and Hughes (1998), we describe the process of development of Adolescent Medicine curriculum at FoM, UiTM and highlight the challenges we faced during this exercise.

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Problem Identification and General Need Assessment

World Health Organization (WHO) defines adolescents as individuals between the ages of 10 to 19 years. Adolescents have their unique health needs. The knowledge of the physical, emotional, cognitive and social changes that adolescents undergo, as well as the disease processes that occur during adolescence, is vital when caring for patients in this age group.

Lifestyle and behavioural decisions made during the adolescent years may profoundly and permanently affect adult health and wellbeing. Most mortality in adulthood has its roots in adolescent period. WHO (2001) estimates that about 70% of premature deaths among adults are largely due to behaviours initiated during adolescence. However these choices and behaviours can be influenced by education and counselling. For this purpose the adolescents should have access to health and counselling services. The realisation of this fact has given birth to a number of adolescent health organisations in almost all the countries around the globe including Malaysia.

Out of 1.2 billion adolescents worldwide, about 85% live in developing countries (WHO, 2001, 2008). In Malaysia adolescents constitute 20% of the population (Merican, 2007). Viner, Coffey, Mathers, Bloem, Costello, Santelli, and Patton (2011) reported that adolescents and young adults have benefited from the epidemiological transition less than children have, with a reversal of traditional mortality patterns over the past 50 years. They pleaded that future global health targets should include a focus on the health problems of people aged 10-24 years.

Targeted Needs Assessment

The majority of causes of adolescent morbidity and mortality are often the result of negative behaviours and the actions of unconstructive forces. WHO’s Adolescent Health and Development Programme has identified four crucial causes of morbidity/mortality in adolescents (a) sexual and reproductive behavior, (b) tobacco use, (c) suicides, and (d) road traffic accidents (WHO, 2001). In addition chronic illnesses are affecting increasing numbers of adolescents as physicians are able to deal more effectively with previously fatal diseases during childhood. The prevalence of chronic diseases in the adolescent population is estimated to be from 7 to 15% (Tan, Shafiee, Wu, Rizal, & Rey, 2005; WHO, 2007). The adolescents must deal with these illnesses while trying to achieve the tasks of normal adolescent development.

Unsafe sex is a major threat to the health and survival of millions of adolescents. Each year one in 20 adolescents worldwide contracts Sexually Transmitted Disease (STD), including Human Immunodeficiency Virus (HIV) infection (WHO, 2001). The young people aged between 15 to 24 years accounted for an estimated 45% of new HIV infections worldwide in 2007 (WHO, 2008).

The incidence of adolescent pregnancy has been estimated about 11% of all births worldwide (WHO, 2007, 2008). In 2005 over 70,000 adolescent girls were admitted in public hospitals in Malaysia and close to 37% were there for pregnancy and related problems (Merican, 2007). The teenage pregnancy is dangerous for both mother and child. Girls less than 18 years of age are two to five times more likely to die in childbirth as compared to women in their twenties; their babies run almost double the risk of dying during their first year of life than babies born to older mothers (WHO, 2001).

One of the most damaging behaviours for the long-term health of young people is the use of tobacco. Most adult smokers begin smoking during adolescence (Khuder, Dayal, & Mutgi, 1999). In Australia approximately one in three young people smoke in comparison with one in five adults (Hill, White, & Effendi, 2002). Of the present population of adolescents worldwide, more than 150 million are smokers and nearly half of them will die of smoking-related causes later in life (WHO, 2008).

Most cases of drug addiction start with smoking (DuRant, Smith, Kretter, & Krowchuk, 1999). The number of drug addicts in
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