Listening and talking to patients

V: Communicating with children

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Ours is a period when the spread of communication has become almost explosive—"pulling the communication cord" is not what it was. I find it surprising that paediatricians have not been in the forefront medically. We might have been expected to be, if only because we explore tentatively the learning difficulties of children and witness the near miraculous speed with which normal and most abnormal children overcome them. The difficulties have been daunting but there is plenty of evidence that the communication problems of children are being penetrated both in theory and in daily practice.

Communication should not be thought of only in terms of the child who can obviously hear and speak. The unborn baby is certainly sharing communication of a sort when he moves or kicks violently in response to an external stimulus. The newborn infant can hardly wait to communicate if given a chance; we have only to observe mother-child eye fixation, the child's response to the mother's cuddling and cooing, the mother's reactions to her baby's smile to recognise that a two-way form of communication is in action. Handicapped children pose further problems.

At the other extreme of childhood we can detect an opposite trend, a decrease in communication. This is not uncommon even in the normal adolescent. The adolescent iron curtain comes down. Communication with adults slows down and may stop altogether. These troubled adolescents for a time become isolated from adults and dominated by their peers.

Middle ages of childhood

The middle ages of childhood hold out some of the most immediate rewards for good communication in general practice. The practical experience (and clinical experiments) of psychologists and doctors show that clearly there are better and worse ways of communicating between children and doctors, just as there are between parents and doctors (as indeed between doctors and doctors). We talk of an approach to communication, but this has to be made up of detail; so do the principles on which it is being built. Every doctor will have his own way of doing such things. Here I shall touch upon some of the details which Dr Ronnie MacKeith¹ and I outlined in *The Child and his Symptoms*. I must step gingerly through the minefields of other doctors' idiosyncrasies.

Putting the child at ease

A surprising number of improvements in communication can be made when the doctor reminds himself that all the time as he is appraising the child and parents so they, in turn, are appraising him.

Before the start of my outpatient clinics I say, and get the undergraduates present to repeat out loud, "If any child cries

it is my fault." As a result it is, of course, rare for any child to cry. Similarly, if students or young doctors cannot manage to examine the patient satisfactorily they are asked to write on their notes, not "Patient did not co-operate" but "I failed to obtain co-operation." Such breakdowns in communication become less and less frequent if the doctor studies them and what led up to them—and how he was able to avoid repeating them. A failure of communication may arise on either side (or on both sides) but it is the doctor who must recognise it and deal with it.

A benign trick that is often successful is for the doctor to emerge from his sanctum, "chat up" the mother in her child's presence, and walk back into his consulting room with them all hand in hand (plus a favourite doll or toy).

If you can get the child to share something with you there should be no battles to fight. Sharing can include the shaking of hands and exchanging names. "Is your name John? May I call you John?" Then, "My name is Doctor Apley" (or even, with a broad smile, "Doctor Apple-pie"). A shared smile or joke goes a long way.

To set the child at ease he should be asked simple questions first, like the name of his nose or of his best friend; or asked to do or share simple things, like "Can we move your chair next to mine?" (If you are so orderly that a desk is needed, I suggest that you share a corner of it, and avoid a boardroom confrontation across the top).

The hospital doctor's white coat represents a form of communication. Should you wear one for the consultation? I do not, but I leave it to my junior colleagues to make a decision for themselves. With increasing seniority, and unless they become surgeons, many of them tend to give up the habit.

In the consulting room, where should everybody sit? The answer is: anywhere. The most amusing seat for a patient is on the rocking horse, but if he gets too excited he may have to be rocked down and thanked. The floor is a very convenient and cosy place on which the child and doctor get to know each other; and from his vantage point the doctor is unlikely to fall into the error of talking down to his patient. The traditional examination couch may be a boon and a necessity; the mother's lap is a comforting alternative. Within moderation, it is well to try to be systematic in the history taking as in the clinical examination, but the routine sequences need not be rigidly adhered to: you can explore the abdomen perfectly well at a time when it seems opportune. Both examiner and examinee need to be prepared and comfortably relaxed. Cold stiff hands and minds, with a monosyllabic monologue, are totally out of place.

I have to confess that I do sometimes offer a reward for co-operation—not only verbal but in the form of a sweet. To call it "operant conditioning" sounds too scientific, but we might include it with numberless other items under the heading of non-verbal communication, and the words "no needle today" are sweet music to the child (though they must be true). A verbal reward is more usual; sweets are special.

Unpleasant forms of examination (including throat and ear inspection) certainly can impair communication. I do not carry out throat examination or rectal examination routinely and unthinkingly; when they are needed the need is patiently explained to child and to parents. The examination is then as quick and painless as I can make it. Like other doctors I keep

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trying to improve the techniques.² Similar remarks apply to the use of other investigations³ to lessen their impact on good communication.

Diagnosing and reassuring

A main purpose of communication is to achieve a diagnosis; and in diagnosis the doctor should be ambitious. I mean he should aim to achieve much more than the obvious and superficial diagnosis.

With acute intussusception or a streptococcal sore throat there is little need to probe deeply, though the benefits accruing from a broad approach will be apparent later. But if the child has recurrent abdominal pain or is not thriving or has asthma the process of communication will need to go further, with suitable extensions of physical probing and non-physical parleys and investigations. The family must, of course, be brought into all discussions (and take a predominant part in management).

Another purpose of communicating is to achieve good management, and one of the most important tools of both diagnosis and management is reassurance. It cannot be over emphasised, as MacKeith² has said, that there should be no reassurance without explanation. Without satisfactory explanation attempted reassurance is self-defeating. Without good communication neither explanation nor reassurance is possible.

In the follow-up of children whose illness is more than transient special thought has to be given to preserving effective communications. If progress is slow, the older child may be seen by the doctor without the parents and this itself often helps strengthen his stance in the family.

"When a family is taken to pieces for study, someone must remember to put the pieces together again." It is normally held that the child patient is best communicated with through the parents, for their emotional lives are inseparable. But sometimes the child's psychosomatic or psychosocial disturbances improve remarkably as a good doctor-child relationship is set up. This very improvement may secondarily relieve the family tensions and so help not only the child but the anxious or stiff-upper-lipped family.

Other and continuing ways of keeping open the channels of communication can be useful. When the child is asked to bring and discuss his school report next time he comes, or is given a story to finish that the doctor has cunningly started, the rapport remains good and its benefits may be reaped later.

History taking

Some important gleanings often precede any sort of formal history taking. A history sheet used like a laundry list is a sign of medical immaturity. It is a skeleton, to be kept in the cupboard. Yes, the novice may need it, but otherwise it is best kept as a check list, to be used after what seems to be clinically relevant has been heard out and perhaps the impression recorded in a sentence or two. I wonder how the doctor manages who tries to maintain a precarious liaison with an anxious parent and touchy child while his pen is scribbling furiously and his head bobbing frantically up and down.

The main presenting features of the history are taken up in a logical way but not omitting some attention to other aspects of the child's well being. A psychiatric history would be out of place without special clues. But at almost every consultation, even with the first for an acute disorder, the doctor should ask a question or two about the child's developmental progress. With a small child who has just had, say, a sore throat one may ask briefly about progress with speech or bowel function. With an older child recovering from gastroenteritis, "Is he mixing well at school and happy about his friends?" The point is to bring to attention early those vital questions "How far and how fast is he progressing developmentally?"

When it comes to reassurance, perhaps unsurpassed by any other method is this one. The doctor turns to a junior colleague or an undergraduate or nurse who is in the room. To him or her the situation is explained lucidly. It is explained without jargon, matched to the mental ability of the parents. The doctor now turns to explain again, to the family. When they go home and try to remember a lot of what they heard said to the onlooker comes out very strongly.

Did I say "No jargon"? The word jargon may be derived from "the twittering of birds." We want none of that here. What we tend to forget is the literalness of children's understanding and talk. When I asked a lad of 7, "Do you like going to school?" "Yes," he said, "I do like going to school, and I like coming home again. It's the bit in between that I don't like."

References

- 1 Apley J, MacKeith R, Meadow R. *The child and his symptoms*. 3rd edn. Oxford: Blackwell Scientific, 1978.
- 2 Apley J. *Paediatrics*. 2nd edn. London: Baillière Tindall, 1979:49-52.
- 3 Apley J. *Paediatrics*. 2nd edn. London: Baillière Tindall, 1979:52-3.

A patient complains of feeling unwell, with a range of vague symptoms such as tiredness, blurred vision, paraesthesia, vertigo, and feeling depressed, which he attributes to living beneath high tension electricity cables. Is there any evidence that such cables are a health hazard?

The growth in the demand for electricity over the years has led to the use of higher transmission voltages; 225 kV has been used for over 40 years and 400 kV for the past 20. Lately the regional office of the World Health Organisation has reviewed work on the effects on man. The organisation held a meeting in West Germany of experts in electropathology and radiation from most industrially developed countries. After making a critical study of the physical and physiological phenomena occurring when a living organism is placed in an electric field, and reviewing publications on the subject, these authors¹ concluded that electric fields were harmless up to transmission voltages of 400 kV. On the basis of current available results for extra high voltage transmission lines, they considered that these conclusions could be extrapolated to transmission voltages of up to 800 kV. It would seem, therefore, that other clinical causes should be sought for the patient's symptoms.

¹ Bonnell JA, Cabanes J, Hauf R, Malboysson E. *Les champs électriques et magnétiques et l'homme*. General World Health Organisation 1979. (CM-22.12.1979-101.47.)

Can the benzodiazepam group of drugs (chlordiazepoxide (Librium), diazepam (Valium), and lorazepam (Ativan) etc) disinhibit cortical control and liberate aggressive tendencies? If so, should their use be considered contraindicated in parents who are likely to cause non-accidental injury in their children?

A disinhibiting action of benzodiazepines has been documented in some patients. Almost all the marketed benzodiazepines may induce aggression, both as rage attacks and as a generally increased level of hostility. Sometimes this is related to too high a dosage but in other instances dosage is normal. Controlled studies on groups of patients, however, show benzodiazepines to be effective in managing behavioural aggression.^{1 2} Therefore, increase of aggression is an idiosyncratic response to the benzodiazepines in some patients. These drugs should be used very cautiously in patients with any history of aggressive outbursts, such as parents thought likely to harm their children. Any increase in hostile feelings in all patients should be inquired for after the first few days of taking benzodiazepines, and the drugs stopped or dosage altered if hostility and aggression have increased.

¹ Kalina RK. Diazepam, its role in a prison setting. *Dis Nerv Syst* 1964;25:101-7.
² Rickels K, Downing RW. Chlordiazepoxide and hostility in anxious outpatients. *Am J Psychiatry* 1974;131:442-4.