PRACTICE OBSERVED

Life Changes

Starting school

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Most children accept and start school with absolute ease and cheerful expectation. Apart from the initial farewell to mummy, they cope adequately with all the novelties and occasional difficulties of being independent for the first time. It seems to be the mothers, who, in their effort to establish that they are not abandoning their little ones completely, more often than not cause anxiety in their children and unnecessary worry for themselves. As a teacher myself, I see these mothers hovering at the gate, watching their children go into school, lingering in case one of them should turn and wave or have a last minute change of heart. At 3.30 pm on the dot they are back again, anxiously waiting while their offspring trolly out with complete indifference. It wasn't so long ago that I was, on the other side of the fence, standing with those mothers.

I can remember longing for the day when my two children would start school and the drudgery and routine of nappies, potty training, "play school," pushchairs, and toys everywhere, would end. How I longed to be able to push my trolley around the supermarket with only food in it! I yearned for the time when I could read a book or wash my hair or even go to the loo alone. I consoled myself with the thought that all the little difficulties I was encountering would be miraculously cured by the advent of school; "don't worry, he'll grow out of it once he starts school."

I am the mother of twins, and as you can imagine I spent five years being absolutely tied to a routine and totally committed to bringing up two very lively and demanding children. When at last the time came for them to start school I actually found myself dreading it. I began to reminisce about cosy days in front of the fire playing with Lego. The walks we used to take by the river.

The sunny days we spent on the lawn with the paddling pool. I forgot about all the hard work and the bad days. I suddenly started to worry that they might not be fully prepared for coping alone.

Could they deal with themselves on the lavatory? Could they hold their knives and forks properly? How well would they cope in a class when asked to do something—would they respond? All these things reflected on me as a mother and the way I had brought them up. Had I done the job properly or had I missed something out? Above all I realised that this one step into school was the first step of independence and, so far as I was concerned, the end of a period in my life that would probably never happen again. I suppose that by worrying about my children, even though they weren't there, enabled me to hang on to a few threads of a past era.

I can remember the day I took the twins to school. Armed with all the correct trappings—new satchels, new shoes, new plimsolls, chocolate biscuit for break, dinner money in a named envelope (I had been up until midnight preparing all this to perfection)—I took them into the classroom. I was getting into a state thinking about how I was going to get out of the room without a scene. I must have been flustering myself. The room was full of toys and games and the teacher was directing children to various corners to take up their activities. The twins looked bewildered by the maffie that surrounded them. I quietly told them not to worry and to remember that they had each other—I might add that I was like a jelly. They held each other's hand firmly and walked anxiously into the room, intent only on two things—the companionship of each other and the activity the teacher was going to give them. I said goodbye, but they never heard me—they just held on to each other, complete in themselves—I didn't matter. I can remember going back and bursting into tears on the steering wheel. I realised for the first time what a complete unit twins were; there was more to their relationship than I had realised. I felt desolate.

I spent my day imagining what they would be doing, hoping that they had eaten their dinner, that they hadn't got lost, that they hadn't wet their pants. At 3.15 pm I was back at the gate. They strolled out without a care. They couldn't answer any of

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the questions I eagerly bombarded them with. They wouldn't remember whether they had painted or coloured, red or counted, and as far as I could gather they had had potato for dinner. They argued all the way back home in the car, had several tantrums, all directed at me, wouldn't eat their tea, and I found myself longing for the next day. In other words, nothing had changed.

It was quite obvious that I was wasting my time worrying; they were far more capable than I was allowing them to be. My initial feeling of desolation passed and within a week I had adjusted. My longing for freedom had arrived—peace at last. The house to myself, a long quiet day. The void was there. Most people lose their children to school one at a time and the change is gradual, with me it happened all at once; it was a case of all or nothing. After five years of being rushed off my feet, I had grown accustomed to the pace and so I went back to work—as a teacher.

Doctor's comment

In the United Kingdom at the age of 5 children have to attend school. Fortunately, most children have an outgoing nature and adapt to this new experience without difficulty. Children, however, are not uniform and react unpredictably to this new environment, which may bring to light behavioural and physical problems previously unrecognized. Starting school requires children separating from their parents, contact with a structured environment, and a new person in authority. Also, children have to adjust to contact with their peers in a group. In the United Kingdom the facilities to help in these changes are variable. In some areas there is easy access to playgroups and nursery and preschool education, but unfortunately such facilities are not widespread and preparation for school is left to the initiative of the parents.

On starting school children come into contact with a fresh branch of the medical services: medical care becomes available from the school nurse and the school medical officer, and continues to be provided by the general practitioner. By law every child has to have a full medical examination on entry to school. In 1981 some 4.5 million children were seen by the school nursing service and one million children had a medical examination performed by the school medical officer.¹ The results of a survey of the school medical services in North Paddington in 1979 showed that on entry to school 40% of the children had appreciable problems related to either physical health or behaviour that would affect their performance at school.² A quarter of the problems were physical, ranging from catarrh to epilepsy, and most were behavioural. Surprisingly, only 6% of the children found to have health problems had consulted their general practitioner in the previous year.

The medical for entry to school is usually carried out by a school medical officer (in some areas general practitioners do this). School medical officers are in a difficult position at present. They are unable to provide a service which would be encouraged to refer children directly for specialist treatment if required. This places them in a limbo, dependent on the general practitioner either following their advice or rejecting it. There is much discussion whether general practitioners should take over the complete health care of children. Until this is resolved a plea must be made for a better understanding between general practitioners and school medical officers. This should be based on a knowledge of each other's skills, with this should come an improved communication between them, benefiting the child.

Before school, developmental screening and immunisation should be carried out by the general practitioner and health visitor. If this system works well any direct problems relevant to school should have been detected before starting school. Once detected, it is hoped that the appropriate treatment would be initiated. An example of this may be found in minor speech problems. Once deafness has been excluded these speech defects can be readily treated by speech therapists. General practitioners,

through their health visitors, have the facility of direct referral to speech therapists.

Children with major physical or mental handicaps, or both, should have been detected before school and their special requirements assessed. These children, however, are usually under the care of many specialists. Once they start school there is a tendency for the general practitioner to lose touch, which may be a disservice to these children. The general practitioner can be a major support and help in bringing together and interpreting all the different information and advice that these children are subjected to.

PHYSICAL ILLNESS

On starting school children come into contact with a new reservoir of infection. There is a sudden increase in coughs and colds, catarrhal states, and the specific viral infections—mumps, chickenpox, rubella, and less often measles (if the uptake of immunisation improves). Children with catarrh are likely to consult the doctor often. Unfortunately, there seems to be no simple remedy to this problem: it is, however, important to watch for an associated condition of glue ear. This leads to a complete deafness which, even when mild, may cause an appreciable delay in reading and learning skills. There is also an association with behavioural difficulties. The main aim of the consultation should be health education. It helps to explain the self-limiting nature of the infections and that simple remedies such as aspirin or paracetamol are required. The general practitioner can emphasise that it would help if the parents were to give up smoking in families where upper respiratory tract infections recur. When an outbreak of a specific viral infection occurs, such as chickenpox, the appropriate advice about symptomatic treatment should be offered, also the time required to be off school should be emphasised. The important liaison role of the general practitioner may be illustrated when there is an outbreak of chickenpox in a school: if there is a child having immunosuppressive treatment for leukaemia it is urgent for the general practitioner to obtain gammaglobulin to protect this child. With children suffering chronic physical illness, it is important to liaise with the school. For example, with children with epilepsy the general practitioner can, with the parents and teacher, enable the child to lead a normal a school life as possible. It is helpful to keep drug treatments to twice daily regimens if possible so that teachers do not have to give out dosages in school time.

BEHAVIOURAL PROBLEMS

Behavioural problems are the most common group of complaints found in young schoolchildren. They are often not present, or not expressed, before starting school. The school is an environment for learning and stimulating social development, but it also provides a stage on which the child may express conflicts and stresses.

Common disturbances of behaviour include temper tantrums, enuresis, hyperactivity, and many somatic symptoms. The anti-social behaviour at school is likely to be dealt with by either the teacher or the school medical officer. The management requires understanding and support for the child.

Children with somatic complaints are likely to be brought to the general practitioner. The commonest symptoms complained of are recurrent abdominal pain, headaches, and aching limbs. It is important to take these symptoms seriously but not to fall into the trap of treating symptoms or overinvestigation and inappropriate investigation. The aim must be to enable the parents and child to understand the association and cause of the somatic complaints and, it is hoped, then improve the child's self confidence. Typically, the child has suffered the complaint for several weeks before the doctor is consulted. There is often a family history of similar problems. Though the com-

plaint is unlikely to have an underlying organic basis (after intensive investigation less than 7% of children with recurrent abdominal pain were found to have an organic cause), it is important to exclude this. Take a history, listen for the associations of the pain, and remember to take a history from the child as well. A full physical examination should be carried out, and simple investigations may include testing urine for sugar and protein, urine culture for infection, and routine haemoglobin and blood count. All these results will usually be normal, and for the parents this simple reassurance is often all that is required. They will accept that the problem is emotional. It is important that they recognise that the pain is real but that support is more important for its relief than treatment of symptoms. The child will rarely lose this type of physical expression of emotional pain: 60-70% in John Apley's survey of children with recurrent abdominal pain either continued to have recurrent pain or developed migraine in adulthood.

Conclusion

Going to school should be a natural progression in a child's development. With good health surveillance before school, few important health problems relevant to education will not have been detected before a child starts school. The general practitioner's main roles are to liaise among the relevant specialists involved in education, support the children and their families through minor problems, and prevent those that appreciably affect the child's development at school.

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Practice Research

Assessing the consultation: method for measuring changes in patient stress and arousal

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Abstract

A method has been developed to assess anxiety levels in terms of stress and arousal in patients before and after a consultation with a general practitioner. The MACL self report mood scale has been used in hospital outpatient studies. An adaptation of the scale using 26 items of low vocabulary was applied to general practice patients in a novel way to show appreciable reductions in stress and increases in arousal after consultations. Since arousal is related to efficiency of performance and stress has been inversely related to recall of information given in the consultation factors that affect stress and arousal in patients could usefully be identified.

Introduction

An objective method was required to assess the effect of environmental variables on consultations in general practice. The change in patient mood from before to after the consultation is a relevant area, being highly sensitive to many aspects of the consultation. Mackay's MACL (mood-adjective checklist) has been used to show that stress and arousal is differentially sensitive to

a variety of environmental, task, and drug effects.¹ Levels of stress on leaving the consultation have previously been related to the patient's recall of information given in the consultation, with lower stress improving recall.² Arousal relates to perform-

TABLE I—Words used in the low vocabulary scale

Stress	Arousal
Uneasy	Keen
Nervous	Alert
Fatigued	Active
Tired	Lively
Bored	Stagnant
Disinterested	Steady
Upright	Drowsy
Alert	Lively
Relaxed	
Awake	
Peaceful	
Content	
Convinced	
Calm	
Cheerful	
Pleasant	
Comfortable	

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ance in accordance with the Yerkes-Dodson law, with higher levels of arousal improving performance on simple tasks as encountered in routine life.³ The MACL scale has yielded appreciable falls in stress and increases in arousal in studies of patients attending a gastroenterology outpatients clinic.⁴ Cruckshank's low vocabulary adaptation (table 1) removes such words as "somnolent" and "quiescent" to become better suited to patients attending general practice.⁵ The scale was

completed easily by patients aged from 12 to over 70, taking from three to eight minutes. It was considered that the reductions in stress and increases in arousal that are generally present after outpatient consultations in hospital may be less universal in patients in general practice because of the wide variety of problems and diagnoses presented and the greater familiarity of the general practice setting to most patients. The direction of change in stress and arousal after consultations was not therefore predicted.

The practice participating in the study is in a health centre and has three general practitioners and one trainee.

Method

The practice operates an appointment system whereby each doctor sees 12 patients in each surgery. Doctors and surgeries (morning, afternoon, and evening) were used in rotation to minimise effects of individual doctor and "time of day." One doctor for each surgery was chosen and three of his patients were randomly selected. The investigator approached selected patients in the waiting room, secured their assistance, and led them to a separate room to complete the scale. The 26 items of the scale were individually and clearly written onto cards, 8 cm long and 5 cm wide. A posting box was constructed with a choice of four slots (table 1). Patients were given all the cards. Using consistent vocabulary the investigator instructed patients to place each word into one of the four slots to try to describe the way they were

TABLE II—Choice of categories displayed on the lid of the "posting box"

I feel slightly	I don't know I feel
I definitely don't feel	I definitely feel

TABLE III—Results of giving MACL to 30 patients attending surgery

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Patient	53	44	40	42	29	40	33	55	13	26	60	38	14	44	18	20	43	20	38	20	36	18	25	24	38	27	16	18	23	18
Before consultation	61	48	35	30	22	25	20	40	25	23	51	53	23	18	18	48	18	20	22	36	18	18	25	24	38	27	16	18	23	18
After consultation	8	10	11	12	7	41	13	15	10	2	5	36	16	8	1	18	17	1	1	1	1	1	1	1	1	1	1	1	1	1
Difference																														

Null hypothesis: The scale will not demonstrate changes in patient stress and arousal resulting from consultations in a general practice situation.

*Two-tailed Wilcoxon test: $t = 56.5$, null hypothesis rejected at 0.01 significance level.

†Wilcoxon = 42.5, null hypothesis rejected at 0.01 significance level.

feeling "at this moment." When patients completed the "posting" they were shown back to the waiting room, having agreed to return after seeing the doctor (to do a second posting, although they were not told they would be required to do it again). The initial card placement were then translated onto a score sheet and the cards were shuffled thoroughly before giving them to patients the second time.

Results

The modified MACL was administered to 30 patients immediately before and after their consultations. The Wilcoxon test (two tailed) was applied to test the null hypothesis that patients' levels of stress and arousal would not be changed by the consultation. For the sum score of the 18 stress items $t = 56.5$, and for the total score of the 8 arousal items $t = 42.5$. (Table III gives individual scores.) These values indicate a significant increase in stress and a significant decrease in arousal from before the consultation to after the consultation. Nineteen of the patients showed a reduction in stress, four showed no change, and the remaining seven showed a slight increase. Nineteen of the patients showed an increase in arousal, five showed no change, and the remaining six showed a slight decrease. Where increases in stress followed a consultation there was a corresponding decrease in arousal, usually showed a clear reason for this in the content of the consultation.

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