PRACTICE OBSERVED

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Practice Research

Common childhood problems: variation in management

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Abstract

A patient management questionnaire was written to assess the range of advice being offered to parents on common paediatric problems. It was sent to hospital doctors, clinical medical officers, health visitors, and general practitioner trainees and trainees. In the 95 completed questionnaires just over half the items elicited conflicting advice, and some differences between different professional groups could be identified. It is suggested that such conflicts are potentially damaging to relationships between patients and health care professionals and that there are ways to avoid conflict.

Introduction

Primary care is being delivered more and more from large and complex units, and some doubts have been expressed about the value of this change. One effect is the increased likelihood of patients consulting with more than one professional for any given problem. This is particularly true for children, who have high rates of consulting and who may see different partners in one practice as well as health visitors and clinical medical officers. Parents may receive conflicting advice on problems, some of which do not have clear solutions. We decided to explore the range of advice given and decisions made by different groups of professionals who are responsible for the care of children, using a descriptive method based on a patient management questionnaire. This is a technique used

mostly in medical education, but it has been applied as a research instrument to study decision making.

Method

A patient management questionnaire was written, based on the history of a child born eight weeks preterm, from birth to the age of 3 years. It consisted of 12 questions about common problems in childhood, of which two were feeding problems, three behavioural, two developmental, and five physical. The questions were independent of each other and required respondents to write a "free text" answer. Some questions related to history and examination, but most were concerned with management, including use and non-use of drugs and specialist services, as well as the advice and explanation given to mothers. The full text is shown in the appendix.

The questionnaire was piloted by asking medical staff in the primary medical care group at this university to complete it. This provided a standard answer based on all of their responses. There was a maximum score for each question, giving a maximum of 50 for the whole exercise. No negative marks were given for responses deemed inappropriate or incorrect. It was sent to general practitioner trainees and their trainees and health visitors in and around Southampton. Some of the health visitors were based in the same practice premises as some of the general practitioners. It was also sent to clinical medical officers in Southampton and Portsmouth and to hospital paediatricians, both consultant and junior staff, in Southampton, Portsmouth, Poole, and Dorchester. They were asked to record their age, sex, and whether they had children of their own. They were asked to try to answer the questions as they would when confronted in their daily practice with the problem described. We scored completed answers using a marking schedule based on the standard answer. To test the reliability of the method 20 answers were scored by both of us; the remainder were scored only once. The method was previously used to study the behaviour of receptionists towards patients.

Results

Table 1 summarises the response rates and results for the six groups surveyed. Of 133 questionnaires sent out, 95 completed forms were returned. 12 others were returned without being completed, four because the

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individual to whom it was addressed was not available at that address and eight because the respondent chose not to answer it. The low response rate among hospital staff (27%) is a result of either the questionnaire evidently being sent to problems most often encountered in primary care or perhaps because they did not perceive teamwork as being an important issue. One consultant wrote that he was not answering our questionnaire as he was being delayed by similar exercises in other subjects. Their answers have been excluded from subsequent analysis.

TABLE 1—Response rates for paediatric management questionnaire and mean scores by groups

	No. sent	No. completed	Score (out of 50)	Mean	Range
Hospital consultants	12	6	15	25.46	10-40
Hospital junior doctors	15	6	11	21.40	10-40
Clinical medical officers	27	21	35	26.46	10-40
Health visitors	25	19	40	29.50	10-40
General practitioner trainees	24	14	24	21.43	10-40
General practitioner trainees	27	21	35	26.46	10-40
Total	133	95	34		

TABLE 11—Child not speaking at age 18 months

	No.	No. mentioning examination	No. mentioning history	Sum of previous responses as a percentage of total possible score	Percentage referring to speech therapist
Clinical medical officers	21	17	18	83	24
Health visitors	19	11	9	53	18
General practitioner trainees	24	14	14	58	29
General practitioner trainees	21	16	15	74	29
Total	85	58	61	70	34

The total response rate of complete answers among the remaining four groups was 80%. The health visitors as a group had the highest mean score, but the ranges for all groups were closely similar. Women scored higher than men (mean 39.1 for women, 31.1 for men), and those of both sexes who had children higher than those without (mean 36.5 for those with children, 24.5 for those without; $p=0.01$ for the difference). The range of scores was 10-40 for those with children, and 10-40 for those without. Of the 20 answers marked by both of us, 16 had scores with 90% or better interobserver agreement.

When assessing agreement or disagreement between respondents the figure of 23 was chosen, somewhat arbitrarily, to denote agreement. Below this was taken to mean disagreement. Note that for binary decisions, such as to refer or not refer to a consultant on a particular question, maximum disagreement would be shown by 50% choosing one answer or that on such items the range is 50-66% for "disagreement" and 67-100% for "agreement." For some questions a choice could be made of more than two options, in which case "maximum disagreement" is shown by less than 50%. Using these ranges, six questions showed agreement, three substantial disagreement, and three a combination of both agreement and disagreement.

In the results below details are given whenever professional groups differed in their responses, no details are given when the groups broadly agreed with each other.

Questions that showed substantial disagreement were as follows:
Q1. Vitamin supplement to prevent malnutrition—79 out of 85 (93%) advised giving vitamin drops to premature babies. This was the question with the most consistent answers in the whole exercise.

Q2. Child bringing cough and acute between 6 pm and 10 pm—69 (87%) of the answers suggested advising alterations to the domestic routine, 24 (28%) considered the possibility of cold, and 23 (27%) recommended a complementary feed.

Q3. Spontaneous rupture of mother at age of 6 months—There was general agreement about how to test for squint: 68 (80%) answers described or mentioned the cover test, and some commented how difficult it is to apply to children of this age. A referral to an eye specialist was advised in 64 (75%) answers. Of those describing or mentioning a cover test, 54 (79%) would still refer to an eye specialist commented with 10 (16%) of 16 who did not mention or describe the cover test. This suggests that the individuals who know more

about squints are marginally more likely to refer a child for a specialist opinion.

Q4. Not talking at age 18 months—58 (68%) discussed a review of developmental milestones and 61 (72%) an examination to exclude physical problems such as spastic or congenital dislocation of the hip; see table II. About one third of respondents referred a child to a hospital specialist for this problem at this age. If for each group the numbers of responses mentioning developmental milestones and physical examination are added and expressed as a percentage of the maximum possible for that question (table II). In contrast to question 6 above, this shows a subject in which the better the question was answered overall the less likely the members of any group were to make a referral. In this case medical officers were least likely and health visitors most likely to refer.

Q5. Temper tantrums—77 (90%) answers considered temper tantrums to be a behavioural problem; 57 (67%) recommended that they should be handled by ignoring the tantrum, and only 10 (12%) thought that the problem required referral to a specialist.

Q6. Chickenpox—68 (80%) answers gave information about the clinical course of the condition, including advice to exclude a child from play school; 62 (73%) gave advice about local treatment to spots or alleviate itching. Questions that showed a mixed response were as follows:

Q7. Management of Nappy rash—more than three quarters of answers included reference to barriers and exposure. Health visitors were

more likely than general practitioners to discuss washing of nappies (84% of health visitors, 19% of trainees, 46% of trainees), whereas general practitioners were more likely to discuss treatment for candidiasis (37% of health visitors, 71% of trainees, 87.5% of general practitioners). For seborrhoeic dermatitis health visitors were again more likely to discuss washing of nappies (55% compared with 19% of trainees and 8% of trainees).

Q8. Prevention of dental caries—49 (58%) advised restriction of sweets and sweet foods. Only 44 (52%) advised addition of fluoride drops or tablets. Health visitors (74%) were more likely to advise fluoride supplements than clinical medical officers (48%), trainees (48%), or trainees (42%).

Questions that showed substantial disagreement were as follows:
Q9. Whooping cough immunisation—To a mother reporting that the hospital doctor had advised her not to have the child immunised for pertussis, 31 (36%) advised immunisation, 23 (27%) advised no immunisation, and 23 (27%) said that they would discuss it with the hospital doctor (see table III). Clinical medical officers and general practitioners were more likely to advise immunisation than health visitors.

Q10. Advice regarding weaning a child at 10 weeks—27 advised weaning, 38 advised against it, and 17 discouraged it but would not oppose mother's wishes; 21% of health visitors advised weaning, compared with 38% of clinical medical officers, 19% of trainees, and 50% of trainees.

Q11. Spontaneous rupture of mother at age of 6 months—Health visitors were more likely than general practitioners and trainees to arrange a hearing test or give advice to the mother about stimulating speech development, or both (see table IV). As in question 9 above, table II the sum of these two responses is expressed as a percentage of the maximum score in the third column. In this case the trend is for those groups scoring higher to be more likely to refer to a speech therapist.

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Discussion

It is important not to place too much emphasis on the overall scores. The differences were small. The marking schedule only gave positive scores and no negative ones, so that a long answer tended to score higher than a short one, and general practitioners and health visitors may have been the result of them taking longer over the questionnaire than other groups.

Doubts have been expressed over the validity of answers that have been obtained in patient management questionnaires, what one person writes down on paper may not accurately reflect his or her actual practice.¹ The format of this exercise asked open questions to represent as closely as possible actual consultations, and it avoided the cueing effect of setting out several options to each question.

TABLE III—Advice on pertussis immunisation in child who received intermittent positive pressure ventilation for hyaline membrane disease and phototherapy for jaundice during a four week stay in the special baby care unit

	No. immunisation	Advice with hospital doctor	Advice against immunisation	No answer given
Clinical medical officers	21	12	4	5
Health visitors	19	12	6	7
General practitioner trainees	24	12	6	6
General practitioner trainees	21	6	7	1
Total	85	31	23	31

TABLE IV—Child not speaking at age of 2½ years

	No.	No. arranging hearing test	No. advising stimulation	Sum of previous responses as a percentage of total possible score	Percentage referring to speech therapist
Clinical medical officers	21	17	11	67	81
Health visitors	19	16	12	74	89
General practitioner trainees	24	10	12	42	50
General practitioner trainees	21	15	6	50	33
Total	85	58	39	57	59

Respondents may have been encouraged to make errors of omission or commission, and this may have exaggerated some apparent disagreements.¹ On the other hand, it is unlikely that anyone will describe on paper a management strategy that is directly opposite to their actual practice, so that the direct disagreements identified here are probably valid.

Within the answers some important conflicts were identified, which are described above. The discovery of persistent disagreement over pertussis immunisation confirms Hull's findings.¹ In retrospect the wording of the question may have been too complex, testing the willingness of respondents to countermand the advice of hospital doctors as much as their own policy on pertussis immunisation. The differences of opinion on fluoride supplements are not surprising, reflecting widespread disagreement among professionals and the general public. There is, however, now a strong consensus among dentists that fluoride confers appreciable advantages, and this will be more so in areas with low levels of fluoride in the water (of which Southampton is one).²⁻⁴ These two issues have been singled out because they are clearly defined questions to which patients might expect unequivocal answers. The other problems that showed substantial disagreement—namely, the appropriate time for weaning and handling children with sleep problems or speech delays—do not intrinsically lend themselves to unequivocal answers so that some level of disagreement is, perhaps, inevitable.

Beyond the general disagreements this study has identified some differences in the behaviour of different professional groups. In treatment of nappy rash, seborrhoeic dermatitis, and sleep problems the general practitioners were more likely to give advice to parents than any other group. This may result from the problems coming to the

general practitioner as a "last resort" after advice from health visitors, or it may illustrate the representative tendency of general practitioners to prescribe drugs in response to many problems.

Secondly, two of the problems on which trainees and trainees scored less well were speech delay and walking delay, and on both clinical medical officers scored higher, an encouraging affirmation of their skill in handling developmental problems. The large difference between the numbers of health visitors and clinical medical officers on the one hand and trainees and trainees on the other advising referral to a speech therapist is not immediately explicable. General practitioners seem either to be unaware that speech therapy is available or to have a poor opinion of its value.

If there is a lack of regard among general practitioners for these

aspects of child development it is no doubt a function of their training, which at both undergraduate and postgraduate level is still rooted in management of acute problems. This study supports those who argue that general practitioners should have specific training before undertaking paediatric developmental surveillance.

It might be argued that the disagreement identified here is unimportant either because the parents will take no notice or because when there is no clear answer advice is defensible. There is little information on the expectations of parents. In a study of women's experiences during pregnancy and the first six months after birth, however, contradictory information was the main criticism levelled at the mass media.⁵ Mothers reported being confused so that they had to rely on their own judgment or interpretation of their babies' responses. Dissatisfaction was especially likely when the information received did not correspond to the personal experiences of parenthood. In addition, a wide range of advice is likely to lower parents' opinion of the professionals whom they consult, an outcome which will be familiar to many doctors.⁶⁻¹⁰ Finally, there are matters such as pertussis immunisation where the advice may be difficult to define and measurable effect on outcome.

One method for avoiding conflict is for groups to develop agreed policies on some common problems, which entails general practitioners developing closer relationships with health visitors and clinical medical officers rather than each group marking out its own territory. We accept that this study, by virtue of its design, was not able to disprove that such activity is already taking place. It may be argued that this is an unrealistic aim or that if realised would result in doctors and health visitors giving rigid advice which failed to pay sufficient attention to the individual needs of patients. An alternative

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is to make every effort to explore their needs, modify the advice accordingly, and trust that a common approach will ensure that an individual receives consistent advice. These two approaches are not always mutually exclusive. A case where they may be seen to oppose each other, however, is shown in the answers to the questions about early weaning (question 4); two groups of respondents were giving advice that they thought was appropriate, whereas a third group thought that they would go along with the mother's wishes despite it not being what they considered "correct."

We have presented evidence that there is substantial disagreement among professionals regarding the management of some common childhood problems—less than many, including ourselves, might have expected, but nevertheless sufficient to cause avoidable confusion among mothers. It is a reminder that effective teamwork does not automatically emerge from a group of people from different disciplines.¹¹ The results of this study emphasise that teams can provide a valuable resource of different skills but that it requires a willingness to work towards agreed clinical goals to ensure that the skills work together to the patients' benefit and not pull in different directions.

We thank all the doctors and health visitors who completed the questionnaire.

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Appendix

Paediatric management questionnaire

This exercise concerns Lucy Holden. Her mother is aged 26, and has been married before but Lucy is her first child. Her father is aged 25 and works as a carpenter on yachts at a boat building yard. They have just moved into your practice area and are living in a terraced house which they own. They were previously living on the Isle of Wight.
Lucy was born at 32 weeks' gestation with a normal delivery, weight 2.12 kg (4 lb 10 oz). She spent four weeks in hospital because of hyaline membrane disease and positive pressure ventilation, and transient anaemia treated by phototherapy. She also received parenteral nutrition. She has now been discharged home in good health.
Shortly after the baby's discharge from hospital you call at the home. Everything appears to be going very well, and Mrs Holden is breast feeding. She asks whether she needs to give the baby vitamin drops with which the hospital supplied her, particularly as a neighbour, who also delivered recently, is not giving them to her baby.
What advice do you give?
(2) A month later Mrs Holden comes to see you at the baby clinic surgery. Lucy is 2 months old and is putting on weight satisfactorily. However, Mrs Holden says that the baby seems to want to feed all the time and is particularly difficult to satisfy between 6 pm and 10 pm when she goes to sleep. She admits that this is a real problem at this time as she is trying to get the evening meal ready.
How can you help her?
(3) At the same consultation Mrs Holden brings up the question of immunisation for Lucy. While in the special care baby unit one of the doctors in the hospital suggested that it was best not to have the whooping cough vaccine.
How do you handle this consultation?

100 YEARS AGO

The Boston mind-cure movement has now become a recognised method of cure in Boston, U.S.A. Hundreds of wonderful cures, said to have been produced by its agency, are proclaimed. The votaries of the movement call themselves "Christian Scientists," and a large proportion of the population, even of the better classes, of Boston has joined the ranks of the new organisation. The fundamental idea of this system of mental healing is that there is no such thing as such a disease as tuberculosis, or cancer, or the results of fear. The mental healer must gain the confidence of the patient, and learn from the patient what he or she considers to be the cause of the ailment. The healer is then to dwell mentally upon the truth and wisdom of God, and thus, "this faith meeting the fear of the patient, produces a chemical change in the fluids of the system which results in health." But, indeed, the theories held by this heterodox mental healer are not far removed from those of the better classes, of Boston has joined the ranks of the new organisation. The fundamental idea of this system of mental healing is that there is no such thing as such a disease as tuberculosis, or cancer, or the results of fear. The mental healer must gain the confidence of the patient, and learn from the patient what he or she considers to be the cause of the ailment. The healer is then to dwell mentally upon the truth and wisdom of God, and thus, "this faith meeting the fear of the patient, produces a chemical change in the fluids of the system which results in health." But, indeed, the theories held by this heterodox mental healer are not far removed from those of the better classes, of Boston has joined the ranks of the new organisation. 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