



Improving Care through Better Communication: Understanding the Benefits

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Often a pediatric consultation consists of communication between the adults in the room, namely parents and pediatricians, with brief communication with children. What do children learn and feel from this type of consultation—is it empowerment or marginalization? Can we do better?

The Challenge

Pediatricians spend many hours of their professional lives talking to families, but how much of their time is spent talking to children. Do they really understand their views on the issues being discussed? As mental health-related morbidity increasingly occupies more time of pediatricians, it appears self-evident that pediatricians should be able to effectively communicate with children and be both confident and competent to talk about the “difficult” or “taboo” areas, such as sex, domestic violence, abuse, self-harm, and even death of children with life-limiting conditions. In fact, pediatricians are taught to diagnose and to treat, and they often present a special and spontaneous motivation to offer child care with a high grade of emotional intelligence and social responsibility to their young patients, which had influenced them to become pediatricians. Pediatricians are also closely attached to their patients’ families, showing high empathy and acknowledging the important role of the child’s family during the healing process. Thus, the emotional scenarios concerning nonverbal and verbal communication in child ambulatory and hospital care and other settings are different from adult medicine. Competent pediatricians may no longer consider communication with children as a challenge by itself, believing that they have done it all the time and have learned by experience. In our opinion, this view seems to be wide-spread and may lead to the underestimation of additional skills for the pediatrician. Learning how to communicate with children of all ages and how to exchange adequate information of different cultural backgrounds should become an integral part of the curricula of postgraduate pediatric training. This also includes systematically learning to handle the child’s rights to health, participation of children during health care, and child-friendly health care in the multiperson setting including the child, the different members of the family, and the different caregivers. We will present a series of articles putting elements of the psychosocial and legal scenario into the center of a debate on inadequacy of child health care services. This report, opens the debate on

the central role of communication between children and caregivers.

The Current Situation in Europe

Professional communication, especially anamnesis and state description between patients and caregivers, always has been an important factor for successful treatment and improved outcome, thus making it an obligatory part of medical education curricula. However, the type of communication will vary with different ages and it certainly changes between various cultures. Most pediatricians, general practitioners, and specialists working with children have received little specialized training on how to communicate with children in a child-friendly and professional way, how to build empowering relationships, and how to handle difficult situations (eg, how to speak with children about serious matters like long-term or life-threatening disease).¹ These tasks may be delegated to psychologists, social workers, nurses, and others, thus marginalizing the role of physicians in the creative process of mutual understanding. This may undermine doctors’ therapeutic competence and lead to patients’ nonadherence to treatment protocols because the different health beliefs and understanding of each other do not match.²

Most European children, when asked to describe their role in medical encounters, reported that they felt marginalized during consultations and that they had difficulties expressing their views and answering questions.³ On one hand, they felt hampered by their parents, who want to protect their child’s engagement and may restrict child participation by interfering in doctor–child interactions, irrespective of their child’s age.⁴ On the other hand, the children did not feel sufficiently invited by their physicians to actively express their own wishes and health beliefs. Doctors were described as too busy and seemed to underestimate the child’s ability to express himself or herself. Thus, the child’s contribution was neglected and—if misinformed—not corrected; therefore, the chances to acquire additional valuable information

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were reduced. Research studies focusing on communication of caregivers with children, not only with their parents, was under-represented until the 1990s and limited to a few countries. Obviously, children experience a consultation differently from their pediatricians; however, children learn quickly from multiple clinical examinations, and their subsequent involvement will depend on the quality of previous child-friendly care.

Untrained medical staff may not be aware of the potentially devastating impact of their routine actions, when being unaware of alternative individual approaches. If the pediatric team has not learned how to handle difficult situations and to build relationships of trust and empowerment for the child, the result will be that pediatricians will talk about difficult children as if they were objects instead of with them as members of a team. Full waiting areas, shortage of members of multidisciplinary teams, and lack of payment for certain services (eg, health education of children and poorly structured organizational and legal settings) may create limitations to the delivery of more child-friendly consultations.

In spite of the above-mentioned challenges, there exists a legal framework for child-appropriate communication; first, the United Nations Convention on the Rights of the Child (UNCRC) of 1989, and second, an approach to “Child-Friendly Healthcare” from the Council of Europe in 2011.

Communication with the Child as Central to Medical Consultation: How Much Effort and How Much Benefit for Pediatricians and Children?

In the field of general health care, the benefit of successful communication of patients and doctors is well documented.⁵ Medical universities have integrated training for professional communication in their curricula.^{6,7} Effective doctor–child communication also is a necessary prerequisite for safe medical care. Communication between pediatricians and children is fundamentally different from communication between general practitioners with adults, thus making specific training an indispensable requirement. Stivers⁸ showed that a child’s behavior during a consultation depends on the physician’s communication skills, and even simple trifles can substantially influence child–doctor interaction. Bates et al⁹ found that the child’s contribution in medical consultations was limited (some 10%) with the medical interaction being dominated by the physician and the parent. Furthermore, Bates et al⁴ described that only few parents and pediatricians supported children to express their views (10%). Having little to no substantial interaction, with the

child, or even talking about the child in the third person, can lead to significant problems for doctors. This will require more time and energy to persuade the child in the future, and having a higher risk that the child will refuse further cooperation or potential noncompliance with treatment leading to long-term sequelae in adult life.

Unfortunately, there is a gap between legal regulations on children’s rights to participate in medicine and implementation of these rights into practice. Particularly relevant are Articles 12 and 13 from 54 Articles of UNCRC, 1989. Governments must assure “to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child: the views of the child being given due weight in accordance with the age and maturity of the child...” Communication has to be based on adequate participation and direct interaction with the child. It is often assumed that children can neither understand nor evaluate relevant medical information, and that they do not know about their own best interests and that, therefore, adults must act for them. Doctors and parents use all these arguments to protect children.¹⁰ It has to be understood and accepted that it remains difficult for adults to accept that even young children are able to understand the seriousness of their disease. ■

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