



Improving Care through Better Communication: Continuing the Debate

Lilly Damm, MD¹, Ulrike Leiss, PhD², Ulrike Habeler, MD³, and Jochen Ehrich, MD, DCMT (London)^{4,5}

This article compliments, “Improving Care through Better Communication: Understanding the Benefits,” by Damm et al (*J Pediatr* 2015;166:1327–1328).

Children’s competence and autonomy develop through direct social personal experience, not only through general developmental age and physical growth. Some of the youngest children can be among the most informed and confident patients if adequately informed. The competence of children depends on the quality of communication with their parents and healthcare providers, and therefore, correlates with the competence of these caregivers to be supportive and generous when delegating knowledge and power to the child.¹ “Children’s decision-making competence is dependent on others’, such as parents and healthcare professionals, attitudes and not only on their own capacity. Lack of competence, however, does not exclude children from the human right to have a say. It should be noted that it is a decision to leave the determination to a parent or healthcare professional.”²

Evaluating a child’s competence poses serious challenges and includes the need for pediatric decision aids (**Table I**; available at www.jpeds.com). Moreover, it is important to assess the competence of the pediatrician (**Table II**; available at www.jpeds.com). He or she must be able to understand all relevant information, to retain and explain all issues clearly and resolve misunderstandings, to assist children and parents in their informed decision making, and to respect their decisions, putting no undue pressure on them. Along with respect for children’s views and values, the whole healthcare team may have to test and stretch the children’s and their own boundaries to inform and involve the children. A realistic approach is needed that respects the limits of clinical knowledge, skills, and factual understanding of children and of the daunting risks and uncertainties in explaining treatment and science.¹ Children have different concepts of health and disease than adults and institutional regulations (**Table III**; available at www.jpeds.com), depending mainly on their cognitive, emotional, social, psychological, and physical development (**Figure**; available at www.jpeds.com).³ They need time and space to tell their story, and caregivers need special skills to inspire them to do so.

In a study by Horwitz et al,⁴ 80% of parents of 4- to 8-year-olds reported having a psychosocial concern worth mentioning to their pediatrician, but only roughly 50% were actually able to have such a discussion. The doctors themselves may have consciously or unconsciously contributed to this hesitancy.

Studies in pediatric primary care have shown that doctors tend to ignore or dismiss the majority of parents’ and children’s hints and disclosures regarding emotional distress.⁵ Many pediatricians are aware of health literacy–related problems and the need for good communication with families, but because of time constraints often struggle to implement communication skills learned previously.⁶

Managing Complex Relationships

When visiting a doctor, children are almost always accompanied by a parent (and sometimes a stepparent); therefore, a complex multiperson relationship (triad) is the norm in the majority of visits. Both parents and children need good communication, each in a special way, which is a sophisticated challenge for all 3 parties. Dulmen et al⁷ pointed out that pediatricians need to be aware that both the parent and the child need sufficient space to contribute to the conversation. In addition, siblings, relatives, or other health care professionals also may significantly influence the interaction of this triadic communication. Additional challenges include limited parental health literacy and the need for emotional support for parents and siblings.

The doctor–parent–child interaction is usually dominated by the adult participants and parents, who, regardless of the child’s age, tend to interfere with the doctor–child communication, and who largely advocate a passive role for the child.

Each participant in the pediatric consultation (doctor, child, and parent) brings certain perspectives, assumptions, and experiences to the consultation, all of which may have a bearing on the ability to achieve a partnership. Gabe et al⁸ emphasized that this partnership involves some degree of agreement, or at least mutual respect, for the different “agendas” that each of the 3 participants may have. Like adults, children have a right to be told the truth and to be treated with respect and dignity. Children in oncology wards

From the ¹Center for Public Health, ²Department of Pediatrics and Adolescent Medicine, and ³St Anna Children’s Hospital, Department of Paediatrics and Adolescent Medicine, Medical University of Vienna, Vienna, Austria; ⁴European Paediatric Association, Berlin; and ⁵Children’s Hospital, Hannover Medical School, Hannover, Germany

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sometimes deliberately protect their parents by not telling them how much they know or suffer, a behavior similar to that of children with nonmalignant conditions. From this perspective, the refusal of a child to openly discuss health matters in serious conditions has a special meaning and should be respected by the caregivers.

Benefits of Good Quality Communication

Effective communication can increase diagnostic accuracy, improve patient understanding and adherence to treatment, and enhance the experience of health services and health outcomes.⁹ The doctor–patient consultation is the basis for health interventions, regardless of patient age. Building a trusting relationship with a child and adolescent improves information transfer and induces better socialization toward an active autonomous patient role with health literacy. It improves the health status of the child through self-determination and self-efficacy, which in turn has a positive affect of health. Interviewing skills that provide support and help in recognizing problems are associated with increased satisfaction and reduced distress for all persons involved.

Children can be coached to effectively develop their role as a health partner (Table IV; available at www.jpeds.com). It is possible to enable children to raise concerns, ask questions, accept information, and participate in the creation and troubleshooting of potential problems with the care plan.¹⁰ Levetown et al¹⁰ reported that children coached in this way preferred an active role in their care, expressed better rapport with the physician, and recalled significantly more information about their medication regimen compared with uncoached controls (77% vs 47%, respectively). Physicians also should encourage parents to coach the child to be an effective advocate for his or her own health. Levetown et al¹⁰ also pointed out that the importance of effective communication skills becomes evident when trying to assess and treat a child's subjective symptom (eg, pain). Without the child's input, understanding the nature and severity of the child's pain is difficult, making it nearly impossible to relieve the discomfort effectively and safely.

Recommendations

Pediatric training should explicitly include communication skills. Effective communication skills can be taught and

learned with minimal additional resources.⁹ Howells et al¹¹ developed the Paediatric Consultation Assessment Tool, an itemized rating scale to rate triadic consultation skills through direct observation. The Paediatric Consultation Assessment Tool allows an individual assessment of child- and parent-oriented communication within 3 or 4 sessions and emphasizes consulting with the children themselves and on information sharing rather than rapport building. Even short periods of training can be effective, through such approaches as motivational interviewing¹² and specialized training in psychosocial topics. Communication training in any curriculum designed to recognize and manage children's psychosocial issues relevant to primary health care settings has been advocated by Wissow et al.⁵ Even brief provider training in communication skills can have a positive impact on mental health communication and it may qualify pediatricians for making short-term interventions. According to Wissow et al,¹³ training built on providers' existing knowledge of child behavior and development can reduce their feelings of lack of competency and fears of losing control over time.

We do not overlook the fact that much more evidence-based information is needed to quantify the positive effect of more active participation of children in communication on treatment outcomes and other variables, such as quality of life, treatment satisfaction, and medium- and long-term effects on child development. There is little doubt that there is a need for well-designed studies to investigate how the partnership with children can actually succeed in practice.

Many questions remain to be answered. To what extent is excellent communication able to shorten the duration of treatment and reduce the number of drugs administered? Is it possible to strengthen health literacy, to decrease the duration of hospital stay, and reduce complications of care? How can education and training in better communication with children and adolescents be developed and harmonized across the various European countries? Implementing existing children's rights to health and concepts like the child-friendly health care model of the Council of Europe into clinical routine are urgently needed to improve the culture of communication between children and their caregivers. ■

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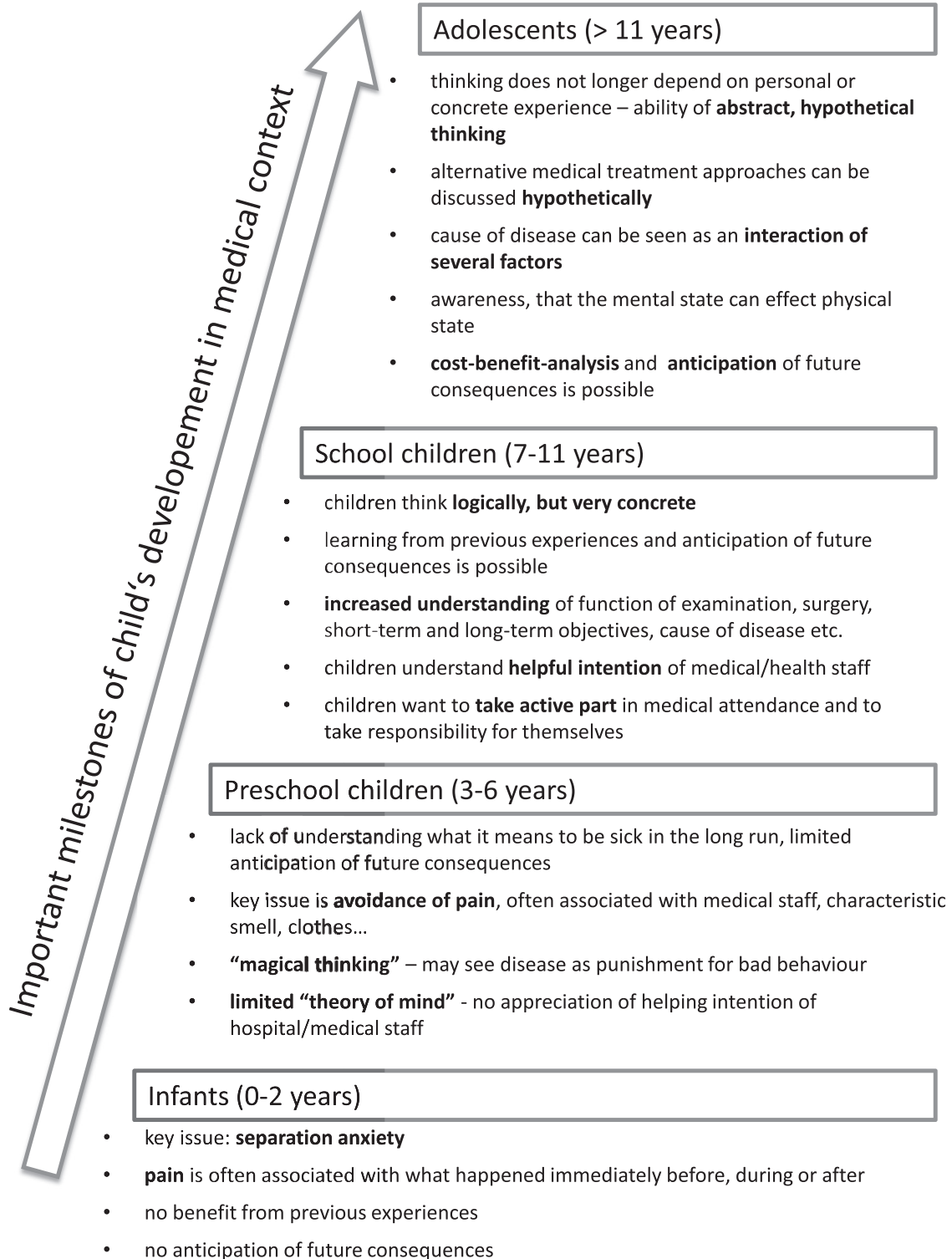


Figure. Timeline of child's development in medical context.

Table I. How to evaluate the competence of the child in the context of medical care with respect to his or her cognitive, emotional, and social development

	Helpful questions	Examples and practical facts considering the child's development
Competence of the child	<p>Does the child ask his or her own questions and talk about his or her worries independently?</p> <p>Does the child have sufficient knowledge of:</p> <ul style="list-style-type: none"> • Body parts, their position and functioning • Health and disease • Causes of disease • Medical/hospital staff; health care services • Physical examinations and procedures? <p>Is the child able to learn and benefit from previous experiences related to health care?</p> <p>Is the child able to anticipate future consequences of health care?</p> <p>Is the child able to see and accept the caregiver's point of view and helpful intent?</p> <p>Is the child able to benefit from other children's experience?</p> <p>Is the child/adolescent capable of abstract thinking?</p> <p>Is the child/adolescent able to understand interaction between several factors?</p> <p>Is the child/adolescent able to consider the consequence of different options of health care</p>	<p>Knowledge of body parts and their position can be evaluated verbally or in drawings</p> <p>Owing to "magical thinking," preschool children may see disease as punishment for bad behavior and feel guilty.</p> <p>Infants and preschool-age children often easily remember previous examinations (eg, recognizes how to use a stethoscope), but are not always able to benefit from the previous experience or anticipate future consequences. Their key issue is the avoidance of pain, which is often associated with medical staff, characteristic smells or clothes, or what happened immediately before or after pain; thus, referring to the past or future does not reduce anxiety.</p> <p>Preschool-age children cannot understand and appreciate helpful intention of medical staff because of limited "theory of mind" (to understand that others have beliefs and intentions that are different from one's own); they cannot benefit from other's experiences. Children between about 7 and 11 years think logically, but most of the time very concretely; it is usually difficult for them to understand abstract language (eg, metaphors) and to discuss hypothetical events.</p> <p>Only adolescents can understand roots–cause–effect–outcome models, the life course model, or that the cause of disease can be seen as the interaction of several factors.</p> <p>Not until adolescence can alternative medical treatment approaches be discussed hypothetically (eg, cost–benefit analysis regarding antipyretic drug as a suppository or liquid).</p>
Competence of the family	<p>Did the family prepare the child for the doctor's/hospital visit?</p> <p>How does the family communicate about disease?</p> <p>To what extent do cultural beliefs influence the family's view of health, disease, and medical procedures?</p> <p>Does the family have previous experience with disease?</p>	<p>Using age-appropriate books, toy medical kits, etc</p> <p>Is disease a taboo? Will there be somebody in the family who will speak with the child about his thoughts or worries?</p> <p>What does the family consider as cause of disease - with regard to their cultural beliefs?</p> <p>Is there a close family member of the child suffering from a serious disease? What does the child know about it?</p>

Table II. How to evaluate the competence of the pediatrician concerning communication with children

Issue	Pediatrician's competence	Practical examples
Opening	Is the pediatrician able to clear up his function for the child? Is the pediatrician able to involve all participants in the counseling, including the child?	The pediatrician knows the child's name and always talks directly to the child, and not about the child.
Knowledge of child's development	Is the pediatrician competent in evaluating the individual cognitive, social and emotional development of the child • To adapt his or her methods of verbal and nonverbal communication? • To distinguish between when the child should be involved in conversations and decisions and when the child would be overstrained?	In preschool-age children, different concepts of time must be considered. The language of youths should be respected, but not imitated.
Knowledge of child's health beliefs	Is the pediatrician aware of age-dependent health beliefs of the child and the impact of these beliefs on communication?	Children aged 4-6 years often can name only 3 parts of the body, whereas adolescents aged 15-16 years can name 13 parts.
Attitude	Does the pediatrician honestly respect the child's opinion and health beliefs, regardless of the child's age? Does the pediatrician respect the child's opinion and health belief as a positive element in the course of disease or treatment?	The pediatrician does not minimize seemingly irrational fears of the child.
Relationship	Is the pediatrician able to build a trusting relationship with the child to get information about the child's individual health beliefs?	The pediatrician gives full attention to child, listens attentively, and uses direct gaze; encourages child to tell his or her story.
Time and setting	Can the pediatrician provide the time and setting to listen to the child's opinions and health beliefs?	The pediatrician explores the parent's and child's ideas, concerns, feelings, and expectations.
Providing information	Is the pediatrician competent to inform the child about relevant medical facts in an age-appropriate and child-friendly way?	The pediatrician uses age-appropriate language and informational materials; uses online commentary.
Decision making	Does the pediatrician recognize and respect the child's right to resist or refuse (perhaps caused by fear/anxiety)? Does the pediatrician involve the parents and child in shared decision making?	The pediatrician provides time and investment in confidence for other possible interventions if feasible (eg, blood draw). The pediatrician informs the parent and child of alternative evidence-based therapy options, clarifies their benefits and drawbacks, and respects the parent's and child's opinions.
Closure	Does the pediatrician establish and clarify the next steps with the parents and child? Is the pediatrician able to close the session in an encouraging way?	The pediatrician expresses appreciation for the child's cooperation and encouragement to attend the next scheduled visit.

Table III. Factors affecting communication with children in health care settings

1. The subjective view (the patient)
 - Patient's own health biography, developmental stages, age, physical growth
2. The objective view (the subjective view of the caregiver based also on his or her own health biography):
 - Knowledge (achieved by education and research)
 - Values (achieved by education)
 - Caring (achieved by empathy, social and clinical skills, and research in public health care services)
 - Technology (achieved by basic, translational, and clinical research and innovation)
3. The interactive view of all
 - Based on open and fruitful communication of all parties involved, mutual understanding, and sharing feelings and values
4. The systemic view (institutions)
 - Regulations (eg, legal aspects, financial factors, organizational limitations, shortage of time)

Table IV. Transferring theory into practice**Attitude and approach: Prerequisites to speaking with children**

1. Show willingness to enter the child's world to see his or her reality as he or she sees it and to hear his or her fears and losses as he or she feels them.
2. Learn to listen to what the child says and how he or she says it (in both formal settings and unexpected moments). Don't judge his or her opinion, but appreciate his or her thoughts; the child's own concepts of disease should not be underestimated.
3. Create room and openness to give the child a say; try to notice small signals.
4. Enable the child to make competent decisions; provide him or her with the necessary tools.
5. Even if the child is not yet competent to take decisions, he or she still has a right to a say.
6. Improve/enhance communication skills and perceive barriers to effective communication; you will create better outcomes.
7. A support system for staff is necessary: a team culture that acknowledges the emotional impact of such work on staff.

Routine medical encounters: Recommendations

1. Speak with the child, not about him or her; do not talk about a child in the "third person" while he or she is present.
2. Consider the child's age-dependent attention span (eg, only 10-15 minutes for 3- to 6-year olds).
3. Improve the likelihood that the child will answer your questions by:
 - Asking social questions early in the visit
 - Phrasing the questions as yes-no questions
 - Directing your gaze at the child during each question.
4. Explain in terms that are appropriate to the child's level of understanding. Use simple language, and avoid complex medical terms and abbreviations; your words may be interpreted very literally.
5. Help the child understand complex procedures through the use of play and/or pictures. Check back with the child about his or her understanding of the previous discussion and ask whether he or she has any new questions.
6. Check with the child about how he or she is feeling, and whether he or she has any specific worries.
7. Outline what is going to happen next, and indicate your availability for further discussion.
8. Three simple communication skills are associated with disclosure of sensitive information:
 - Asking questions about psychosocial issues
 - Making supportive statements
 - Listening attentively. Doctors should not practice multitasking, like writing down notes, having parallel phone calls giving orders to nurses, etc.
9. If a child or adolescent chooses to not discuss the disease despite open information and the opportunity to talk, respect his or her choice.
10. Try to understand that a child who do no longer speaks or communicates with you may have started a journey of no return, and that his or her silence could also mean "protecting parents and siblings."
11. "Let Mum have her say"; manage turn-taking in doctor-parent-child communication.
12. When working with an interpreter make sure the interpreter has an understanding of developmentally appropriate concepts and language for the child.
13. Respect the family's spiritual (even mystic) health beliefs and cultural practices when communicating with the child and the family, but do not follow their track and create new "confusion of thinking."

Speaking to children about serious matters: Recommendations

1. Children are interested in health, illness, dying, and death, and they have the right to respect and the truth.
2. Before talking with the child, talk to the parents to give them the information and plan with them how best to talk with their child.
3. Ways that meeting with a child might then proceed: the child together with the parents/primary caregiver; the child without parents, to give the child the chance to discuss subjects that he or she may feel unable to raise in front of their parents; the child/adolescent with another support person, such as a friend or partner; and the child and parents after the parents have talked to the child.
4. Ensure that the setting is appropriate, that is, private, child-friendly, and safe. Arrange to have everyone seated, and if the child is confined to bed, ensure that adults are not standing over the child.
5. Explain in terms that are appropriate to the child's level of understanding: use simple language, avoid complex medical terms and abbreviations, words may be interpreted very literally. Help the child understand complex procedures through the use of play and/or pictures.
6. Ask the child what he or she knows about the illness and/or treatments to date.
7. Check back with the child about his or her understanding of the topics discussed and ask if he or she has any questions.
8. Ask the child how he or she is feeling, and whether he or she has any specific worries.
9. Outline what is going to happen next, and indicate your availability for further discussion.
10. Check with the child about how much he or she wants to know.
11. If a child or adolescent chooses to not discuss the disease despite open information and the opportunity to talk, respect his or her choice.
12. When working with an interpreter, make sure the interpreter has an understanding of developmentally appropriate concepts and language for the child.
13. Respect the family's spiritual beliefs and cultural practices when communicating with the child and family regarding illness and death.

Modified from data in Skeen,¹⁴ Stivers,¹⁵ and Wissow et al⁵.