

# COMMUNICATION WITH PEDIATRIC PATIENTS: MORE THAN A MEDICAL ACT

Smaranda DIACONESCU<sup>1,2</sup>, Ștefana Maria MOISA<sup>1,2</sup>

<sup>1</sup>„Grigore T. Popa” University of Medicine and Pharmacy, Iasi, Romania

<sup>2</sup>V<sup>th</sup> Pediatrics Clinic, „Saint Mary” Children’s Emergency Hospital, Iasi, Romania

Corresponding author: turti23@yahoo.com

## Abstract

Pediatricians face unique challenges when trying to communicate with children and family members. Effective communication is more crucial and more complicated than it is with adults, leading to unique situations that necessitate increased abilities. A pediatrician should adapt communication skills to a continuously changing interlocutor. Among children with special communication needs are teenagers, children from intensive care units (preoperative and post-surgery phase), oncology patients, children with hear loss, mental disabilities and, due to global migration and refugees crisis, children whose primary language is different from the physician’s language. When talking to a child and his family, a doctor must follow four Es – engagement, empathy, enlistment and education; other factors influencing child’s and family’s perception of the message are the age, physical appearance, experience, “know-how” and vocation. According to these trends, an improvement in communication with pediatric patients should be a continuous concern in Romanian children’s hospitals.

**Key words:** *Children, Communication, Pediatrician*

## 1. INTRODUCTION

Children’s hospitals face unique challenges trying to make practical improvements in their communication with children and family members. Effective communication is more crucial, and often more complicated than it is with adult patients, leading to unique situations that necessitate increased abilities. Studies (Farrell, 2001) have shown that poor delivery of the message is common in pediatric settings, leading to high levels of parental dissatisfaction and may reflect the lack of training health care professionals generally get for these situations. Verbal, nonverbal, and electronic communication abilities vary greatly among patients and physicians of diverse generations. Pediatric medical communication has particular aspects that differ in structure, format, and content from

adult patient medical communication. Pediatric visits are particularly challenging in requiring that the physician engage in a dance with not one but at least two partners -parent and child - and that the physician be able to lead at times and follow at others. The communication between pediatrician, children and parents is similar to a triad, each part having particular role and involvement.

## 2. COMMUNICATION WITH THE PARENTS

The parental status is important in determining the attitude and the expectancies towards the medical staff: the parents may be hospital first-timers, youngsters accompanied by their own parents, single, divorced, remarried or recent immigrants whose primary language is not Romanian. They may be burdened by the responsibility of making decisions for their child or unrealistic in their expectations for their child’s potential (Farrell, 2001). Studies (Levetown, 2008) have shown that the relationships with practitioners are a major parental complaint of health care practice. An effective communication between physicians and patients/parents include interest, caring, warmth, and responsiveness. Thus, it’s not surprising that relationships between parents and doctors have an important effect on parental satisfaction, recall of instructions and treatment adherence. Some studies revealed that these are more importance for patient satisfaction than having to sign an informed consent. (Levetown, 2008) On the other hand, a sometimes subjective perception on the doctor’s behavior (i.e-when the

patients feel they are disrespected or have not talked enough about their fears) makes parents doubtful regardless of the amount of information provided. In some pediatric hospital settings the usage of audiotapes is provided to allow parents to repeatedly listen to the information and to enable dissemination of information to others who could not be present. This particular aspect is very important, since parents frequently ask for other people's opinions in making healthcare decisions for their children, whether it is their own parents, other doctors, other relatives, friends or sometimes religious leaders.

### **3. COMMUNICATION WITH THE CHILDREN**

---

Pediatric patients may range in age from newborns through adolescents; thus, a pediatrician should adapt his or her communication skills to a continuously changing interlocutor. Because emotional development and cognitive abilities evolve with age, pediatric patients may be oblivious (infants), uninformed (children), or invincible (teenagers). Their communication modes are sometimes influenced by the presence of their parents; parental presence in the room may be an intimidating factor. The obligation to discuss healthcare with the child patient is supported by several international laws, policies, and court decisions (e.g. *Bellotti vs. Baird*, 443 US 622 [1979]); moreover, a better communication will allow children to be active participants in their healthcare. There are several reasons that determine children's fear of doctors, nurses and hospital settings in general, and these are the anticipation of painful events, an unfriendly or unknown environment, the unfamiliar faces, the lack of understanding the medical act and, last but not the least, "the doctor/shot" threat that is frequently used by the parents. Regarding this last aspect, children are also frightened by worrisome stories heard from older siblings about an upcoming doctor's visit. But little patients can be coached to effectively assume the role of a health partner as they often understand more than it has been assumed; coached children prefer an active role in their care and have better rapports with the

physician. This is a particular important issue, as the child's satisfaction with healthcare communication may shape a life-long attitude toward doctors, the healthcare system and the patient's receptiveness to later interventions or recommendations. Later in his life, when the child becomes a parent himself, his impressions and memories of doctors, medical procedures and hospitalizations may influence the attitude he or she will transfer to his/her own children. Being respected, listened to, and understood - as well as understanding the reasons for a medical procedure or recommendation - can set the stage for a child's future performance. Children need to have usable information, to be given choices and to be asked their opinion because enhanced understanding provides a sense of control, which mitigates fear thus reducing the harms associated with illness and injury. To this end, several methods can be used, such as videos or role playing. The goal is to allow children to ask questions and take part in decision making. The best attitude is to involve children in communication and in decisions about their health; this shows respect for their capacities and enables them to be more than a pawn in the decision making process.

### **4. DOCTOR'S ROLE**

---

When talking to a child, a pediatrician should apply the four Es - Engagement, Empathy, Enlistment and Education. Several factors may influence both the impression that the doctor produces on children (i.e. age or physical appearance) but also his/her communication skills (i.e. the level of experience, the level of professional stress, the "know-how" and finally, the vocation). The doctor's abilities to communicate with children are by far best evidenced, for example, in the situation where an informed consent (assent) from an informed child or adolescent should be obtained. These children can weigh the pros and cons of the proposed intervention and may start debates with the treating physician and with their parents; it's the doctor's role to use a simple but comprehensive language to explain a procedure or a proposed treatment, the benefits and the risk

and to provide all the details a child is asking for. According to the US laws, teenagers below 18 need their parents' permission to make healthcare decisions. This is not the case of emancipated minors, like those who are enrolled in the army, those who are already parents or those who are emancipated by court. Other states recognize "mature minors" by similar criteria. In the European Union a mature minor gives his consent, but the consent of a parent is also welcomed and might even be required.

## **5. PRACTICAL ATTITUDES**

Some practical attitudes may help doctors to better communicate with the children. The words a pediatrician uses must be carefully chosen and negative connotations should be avoided; instead of "deformity" we should use "appearance", instead of "shoot an X-Ray" we should use "take a picture", etc. (Mesko, 2011). The voice should be loud and sometimes whispering, as children usually become so intent on trying to hear what somebody else is saying that they forget their fear and focus their attention on the speaker. On the other hand, children are much attuned to facial features (i.e. frowning at an X-ray) and are definitely influenced by the smells, sounds, and surroundings of their medical visit. Pediatricians and medical staff working with children should use simple words, loving tones, be playful and portray learning through play and also should use lots of repetition, rhythm and songs. Another valuable idea is to use visual impact to reassure the patients, as wearing brightly colored scrubs will make children smile or to use a communication intermediary such as a nurse, a sibling, a parent and sometimes even a puppet. Some hospitals use specific communication tools such as a pictured dictionary of medical terms including a section on various kinds of injections, with images and videos or a special place where kids can post stories or messages about their experiences; for parents, advice pages covering topics such as how to explain to kids what will happen in the hospital and how to comfort their children is provided. Sometimes a visual scale of pain that uses six faces that show an increasing degree of discomfort is used to better indicate

the intensity of a child patient's pain. Other instruments may include a double-sided communication tool with a communication board on one side and written messages on the other, a phrase-board, designed for patients with speech difficulties (users can indicate where and how much they hurt with scrollable lists and a chart of the human body, type or draw messages) or special apps conceived to divert children while in hospital.

## **6. DIFFICULT COMMUNICATION ISSUES**

Even in the richest world's nations where health policies are supporting the medical communication system, there are many categories of patients, including children, which raise particular problems. One of the most important categories is the teenagers, as their age-related life-style changes affect compliance and adherence to various medical procedures and treatments. Adolescents often manifest a refusal of the diagnosis, especially in chronic or severe prognosis diseases; they tend to fight against the rules, they become more preoccupied by their physical aspect thus damaging, for example, dietary recommendations in case of chronic illness.

Important communication problems are raised by children and families whose primary language is not the same as the physician's. This situation may occur due to an extended phenomenon of global migration, to the recent evolutions of the refugees' crisis, but also, as a "local" phenomenon in Romania, when doctors are treating patients originating from Roma communities. Regarding this aspect, the disparities in the health status between Roma and non-Roma are frequently explained in terms of economic inequalities but also due to an overrepresentation of Roma in the categories of the uneducated or poorly-educated people and in a higher exposure to health-related risk factors such as poor living conditions. Communication with minority and non-Romanian-speaking families may be disturbed by language barriers or inappropriate cultural or religious expectations, and that may lead to a decrease of healthcare level. The practitioner must foresee

and prevent such situations. Sometimes the doctor might find himself in the position where the parent does not put the child's best interest first, but the best interest of the whole family; sometimes decisions are not made by the parents, but by the whole extended family; sometimes the parents lack basic medical education and may have special needs. In these situations, the doctor must exercise patience and offer a lot of his time to these families in order to make sure their decision is informed.

Of crucial importance is the understanding of the fact that children with complex communication needs, who cannot communicate by natural speech on their own, have the same social, emotional or physical needs as other children. Communication supports, also known as augmentative and alternative communication help these children express themselves in ways that extend beyond basic needs. The so-called Matrix is an instrument designed to assess non-verbal communication of disabled children, using drawings, facial expression, body movement, but also speech and writing. It is particularly useful in children younger than 2 years old and in-patient rehabilitation. Many hospitals collaborate with speech-language pathologists who recommend the best forms of communication supports, including augmentative and alternative communication (AAC), based on a child's specific needs and abilities. (Calandrella, 2000, Holte, 2006, Rowland, 2010, 1989, Proctor, 2008)

Probably the most difficult situation of all is the communication of bad news in ICUs, ERs and palliative-care units in case of terminal illness. Children undergoing palliative or end-of-life treatment have special needs and emotions. Parents value a caring attitude of the physician offering unfavorable prognosis and an opportunity to talk about their feelings. Parents may easier understand the child's likely course if they had previous experience with the disease or know other patients suffering from the same condition.

## 7. CONCLUSIONS

---

Communication is more and more assimilated to a medical procedure. Communication for

children should be age-appropriate and child-friendly and should use child-appropriate language, characters, stories, music and humor. In pediatric settings it is not limited to obtaining a history. When most effective, communication continues through physical examinations, treatments, and follow-up care. It is the clinician's responsibility, it cannot be delegated, and it has lasting effects over time. A continuous improvement of the communication skills and a caring attitude of the physician are must-have attributes in child healthcare.

## References

---

- Justia US Supreme Court. (1979). *Bellotti v Baird*. [Online] Available from: <https://supreme.justia.com/cases/federal/us/443/622/case.html>
- CALANDRELLA, A. & WILCOX, M.J. (2000) Predicting Language Outcomes for Young Prelinguistic Children With Developmental Delay. *Journal of Speech Language and Hearing Research*. 43(5). p. 1061-1071.
- FARRELL, M., RYAN, S. & LANGRICK, B. (2001) Breaking Bad News within a Paediatric Setting: An Evaluation Report of a Collaborative Education Workshop to Support Health Professionals, *Journal of Advanced Nursing*. 36(6). p. 765-775.
- HOLTE L, PRICKETT J., VAN DYKE D., OLSON R., LUBRICA P., KNUTSON C. (2006) Issues in the Evaluation of Infants and Young Children Who Are Suspected of or Who Are Deaf-Blind. *Infants and young children*. 19(3). p. 213-227.
- LEVETOWN, M. (2008) Communicating With Children and Families: From Everyday Interactions to Skill in Conveying Distressing Information. *Pediatrics*. 121(5). P. 1441-1460.
- MESKO, P.J. (2011) Use of picture communication aids to assess pain location in pediatric postoperative patients. *Journal of Perianesthesia Nursing*. 26(6). p. 395-404.
- PROCTOR, L. & OSWALT, J. (2008) Augmentative and Alternative Communication: Assessment in the Schools. *Perspectives on Augmentative and Alternative Communication*. 17(1). p. 13-19.
- ROWLAND, C. & FRIED-OKEN, M. (2010) Communication Matrix: A clinical and research assessment tool targeting children with severe communication disorders. *Journal of pediatric rehabilitation medicine*. 3(4). p. 319-329.
- ROWLAND, C. & SCHWEIGERT, P. (1989) Tangible Symbol Systems: Symbolic Communication for Individuals with Multisensory Impairments. *Augmentative & Alternative Communication*. 5(4). p. 226-234.