Improving Care through Better Communication: Continuing the Debate

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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 al[7] 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 al[8] 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

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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 al[10] 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 al[10] 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 al[11] 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 interviewing[12] 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. ■

References available at www.jpeds.com