

Communicating about expected course and re-consultation for respiratory tract infections in children: an exploratory study

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SUMMARY

Acute respiratory tract infection is the commonest reason for children consulting, and about one-fifth re-consult for the same illness episode. Fifty-nine audiotape recordings from nine general practitioners (GPs) consulting with children with acute respiratory tract infections were examined. Prognosis was mentioned in only 22 consultations, with GPs predicting a brief course in 11, a possibly longer than expected course in six, and with predicted duration not made explicit in five. Carers were invited to re-consult if they were 'unhappy' with the child's condition in 11 consultations, and specific triggers to re-consult were provided in 15. A patient information leaflet was given out only once. Providing carers with an evidence-based account of the likely clinical course and communicating specific triggers to re-consult may help them manage more of these illness episodes without re-consulting.

Keywords: children; infections, upper respiratory; patient education; physician-patient relations; prognosis.

Introduction

ACUTE respiratory tract infection is the commonest single acute indication for children to consult in primary care.¹ About 20% of children re-consult for the same illness episode, a figure that has remained fairly constant over the past 20 years.^{2,3} Most of these infections are self limiting, with little to be gained from antibiotic treatment. Providing appropriate information to carers may help them manage these illnesses without re-consulting unnecessarily and could reduce pressure on primary care services and unnecessary antibiotic prescriptions. Carers value clear information about what to expect when their children are ill.⁴ Adults consulting in general practice with cough re-consult less often for the same illness episode if given a clear idea of the natural history of their illness.⁵ In 1979, Stott wrote:

... second consultations for children with uncomplicated upper respiratory tract infections are often initiated by parents because the illness has not followed its expected course. Doctors often encourage mothers to return "if the child doesn't get better", or they use vague, reassuring generalisations such as "it is only a cold and will be better in a few days".³

However, we are not aware of any published data on what general practitioners (GPs) actually communicate to carers about what they should expect when their child has an acute respiratory tract infection. Therefore, audiotape recordings of consultations with children with respiratory tract infections were analysed in order to explore GPs' current practice regarding communicating the likely course of these illnesses.

Method

Nine GPs from two general practices were recruited to help develop and pilot an intervention aimed at enhancing the management of children with acute respiratory tract infections. The practices were selected for their interest in helping with the research and because they were well organised, had at least four partners, and were situated in one of two contrasting locations. All consultations with children aged 10 years and younger during selected surgeries were audiotaped after written consent was obtained from carers before seeing the GP. Only transcripts of consultations where the main presenting problem was a respiratory tract infection were included in this analysis. The study was approved by the Bro Taf Local Research Ethics Committee. Two of the authors independently examined the

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HOW THIS FITS IN*What do we know?*

Acute respiratory tract infection is the commonest reason for children consulting their general practitioner, and about one in five re-consult for the same illness episode.

What does this paper add?

Providing carers with an evidence-based account of the likely clinical course and communicating specific triggers to re-consult may help them manage more of these illness episodes without re-consulting.

included transcripts and extracted all instances where clinicians communicated about prognosis and re-consulting. Extracts relating to prognosis were divided into those indicating an illness duration that was short, possibly longer than expected, and not explicit. Regarding re-consulting, extracts where GPs indicated a general willingness to review the child were differentiated from those providing specific triggers to re-consult. Typical illustrative quotations were agreed for each category. Disagreement was resolved by joint re-examination of transcripts.

Results

Audiotape recordings of consultations were obtained for all nine eligible GPs. The number of recorded consultations with each GP ranged from two to 12, reflecting variation in the number of eligible children consulting with each GP and the numbers of surgeries done by individual GPs during the study period. A total of 59 transcripts were included in this analysis.

GPs mentioned prognosis in 22 consultations. In 11, GPs indicated that the illness would be over fairly quickly. Typical examples of terms used to express the prediction of a short duration were:

'He should fight it off now in the next few days, OK?'

and:

'She'll probably be OK for school next week.'

In six consultations, GPs indicated that the illness could last longer. A typical example of this more cautious prediction was:

'Mostly what happens is the kids will cough their heads off for a week or more and quietly get better.'

In the remaining five instances where GPs mentioned prognosis, there was no clear indication of the expected length of the illness. An example of this is:

'There is no predicting the outcome of this.'

GPs told carers that they should re-consult if they were 'not happy' with the child's condition in 11 consultations. However, GPs discussed more specific triggers for re-consulting in 15 consultations. Examples include:

'The things you've got to look out for if she's not eating is obviously a little bit of dehydration, and the first thing that

will happen is that she will stop wetting her nappies, and if that happens then you need to let us know.'

and:

'A good sign that he needs to go into hospital is when he's too breathless to drink.'

Only on one occasion did a clinician provide a carer with a patient information leaflet.

There was a tendency for a few GPs to communicate often about prognosis and re-consultation, rather than for all GPs to do so infrequently. For example, 11 consultations with one GP were included, and he communicated about the expected course of the illness seven times and provided information about specific triggers to re-consult four times. In contrast, 10 of one GP's consultations met inclusion criteria, and he communicated about the expected course twice and provided information about specific triggers to re-consult only once.

Discussion

In this exploratory study, the expected course of the illness was mentioned by GPs in a minority of consultations involving children with respiratory tract infections. When the expected course was discussed, prediction of natural history varied widely, reflecting the broad criteria for including children in the study. However, clinicians more commonly predicted a short illness duration. Clinicians expressed a willingness to review children if carers 'were not happy' in about one in five consultations, and only 15 examples of communicating about specific eventualities (including a prolonged course) that should trigger a repeat visit were found. It is possible, therefore, that carers are sometimes left with the impression that a child with a respiratory tract infection should get better within a few days and that they should re-consult after that time if the child continues to be symptomatic. Clinicians underestimate the duration of acute cough in children.⁶ A systematic review of studies showed that after 2 weeks, 25% of children with cough may be no better.⁷ We previously found that over half of children consulting with suspected acute viral upper respiratory tract infection were still unwell 4 days later.²

All GPs participating in this study were aware that the overall aim of this research programme was to enhance communication in the management of respiratory tract infections in children, and all were responsible for audio-taping their own consultations. Bias is therefore likely to have been in the direction of better communication performance. GPs may have focused more on discussing management rather than prognosis, as they were also aware that the researchers were interested in the issue of antibiotic prescribing.

These consultations provided examples of good practice for setting realistic expectations regarding the expected course of respiratory tract infections in children. However, from the data presented, it appears that there are opportunities for enhancing communication about the likely or possible clinical course in many consultations, and for greater use of patient information leaflets. Sharing evidence about what children who have respiratory tract

infections should expect, including the evidence for wide variation in illness duration, may therefore help carers to manage these illnesses without re-consulting. In addition, carers may benefit from more detailed information about signs that can be monitored and about which ones should trigger re-consultation. However, development and evaluation of such communication skills interventions should take into account the potential for increased anxiety associated with carers' increased monitoring responsibilities.

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