

care shift in which services would move 'closer to the patient' (that is, closer to the GP). This policy direction was further emphasised in *Our Health, Our Care, Our Say*<sup>19</sup> which contains some memorable images, including that of hospital gynaecologists, orthopaedic surgeons, and urologists decamping to community settings to deliver their services.<sup>20</sup> These community settings may be only a few hundred yards from a large teaching hospital, and the care provided there may be more expensive and no better than that provided in a hospital clinic.<sup>21</sup> Policy analysis in this document is sometimes at the Orwellian 'secondary care bad, primary care good' level of sophistication.

The future of the NHS is likely to depend, to a large extent, on the future of general practice.<sup>22</sup> At present, a disfigured general practice system is struggling to hold on to core skills, attitudes, values, and behaviours, in the face of a series of professional and governmental initiatives which have, successively, damaged its effectiveness. Further de-personalisation of general practice and increasing centralisation of services, particularly where general practices are already doing a good job, will accelerate this process and have the potential to impair the primary care sector's ability to moderate demand for specialists and expensive technology.

The health economic impacts of a weak primary care sector can readily be seen in the US,<sup>23</sup> while the effects on morale and patient care of the fragmentation of general practice are apparent in New Zealand's health system.<sup>24</sup> The government and its advisers not only need to appreciate the important role that general practice has in

demand management and cost containment, but also need to understand the complexities that lie behind general practice and the dangerous territory into which an over-simplified view of primary care in the NHS will inevitably lead.<sup>25</sup>

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## Talking to children

Children may have varied expectations of going to see a doctor, depending on age, what parents have said, and previous experience of health professionals. Many children might expect the doctor first to find out what is wrong, perhaps by asking questions, by prodding, by sticking a needle in, or by just knowing. I remember

once, as a paediatric registrar in Hackney, asking a Bangladeshi father whose wife spoke no English what was wrong with their child. He said that I was the doctor, so I should know. I would have done better to ask the child.

Children may often be dissatisfied with their interactions with health professionals,<sup>1</sup>

but may not say so unless asked, unlike their parents, who may insist on having their say. A simplified case example follows to illustrate the need to allow children to voice their concerns. A 10-year-old boy has recurrent abdominal pain that often begins on schoolday mornings, mostly gets better on Friday evenings, and

improves if he is driven to school by his dad. He had not told anyone, until his school nurse asked him directly, that he was being bullied on the bus on the way to and from school. In general practice children with social or educational stress very commonly present with symptoms that could be regarded as partly psychosomatic, such as bed-wetting, asthma, recurrent abdominal pain, and headaches.<sup>2</sup>

Children's ratings of the doctor's interviewing skills may not be as reliable as those of the parents,<sup>3</sup> but it is likely that diagnostic assessment will be more accurate if the child contributes. The child will appreciate feeling heard and the treatment is likely to be more effective if the child is involved in discussing what can be done.

There are structured ways to assess and improve communication skills with adolescents<sup>4</sup> as well as children.<sup>5,6</sup> Trainees' communication skills can be improved by recording on videotape a proportion of routine consultations (Sue Laurent, personal communication, 2004). Triadic consultation skills can and should be taught in both general practice and paediatrics — but not in a single session. Ideally, four components should be involved:<sup>5</sup>

- small-group or one-to-one learning;
- observation (preferably involving video-recording and role-play);
- detailed, individualised feedback; and
- practice/rehearsal of skills.

All UK medical schools now teach communication skills, and a proportion devote part of this syllabus to communicating with children, but not all have a specific module on the triadic consultation skills necessary to interview a child and parent (or carer) together. This is more likely to be learned during postgraduate training, but it needs to be actively taught at an early stage. Two fascinating papers by Cahill and Papageorgiou in this issue focus on patients aged 6–12 years. They present a thorough review of relevant research,<sup>7</sup> and a description of the authors' own well-designed study,<sup>8</sup> with resulting recommendations.

There is some research on how to teach triadic communication skills;<sup>5,6</sup> and on

what actually happens in general practice and paediatric consultations, as reviewed by these two authors.<sup>7</sup> There is less research determining the best techniques to use in triadic communication (in addition to those of a generic clinical consultation). The sparse literature is reviewed by Crossley and Davies.<sup>9</sup> However, there is significant overlap between these three categories: how best to teach the skills specific to triadic consultation; what skills interviewers use in practice; and what skills are best to use. Researchers assess and trainers teach what they believe to be the most useful skills. Children's views on the skills of the doctor they have seen may provide useful individual feedback, although parents may be more consistent in understanding the questions, and give a better comparison of skills.<sup>3</sup> Females at 14 years of age were found to rate videotapes of clinical interviews reliably,<sup>4</sup> which could be used to determine the best triadic communication skills; however, younger children would have difficulty with the readability of the scoring items.<sup>4</sup>

The recently published GMC guidelines<sup>10</sup> were developed partly as a result of focus groups involving families.<sup>9</sup> The research on which skills interviewers use in practice<sup>7</sup> uniformly indicates that the child is involved for too small a proportion of the interview: ranging from 4% to 14%. Beyond that, there seems to be scope for professional consensus,<sup>9</sup> and also for some disagreement about the best way to involve both parent and child.

For instance, there is the potential for disagreement with two small aspects of the recommendations these authors make (Avril Washington, personal communication, 2007). Firstly, the parent should not necessarily be allowed to speak first. The child could be greeted first in the waiting area and then, after some problem-free chat (if there is time), given the opportunity to provide a version of the presenting problem. Parents can be reassured that their version will be allowed later and, if possible, should not be allowed to impose their views on their child's. Secondly, the authors' advise against 'motherese',<sup>8</sup> which presumably means a sing-song variation in tone that can be good at maintaining attention, but it is unclear

whether there is enough evidence for this, particularly in younger children. The younger the child, the more effort the doctor must make to simplify concepts. Modulation of voice tone and syllabic stress can also helpfully be adapted to age; this is no more than an exaggerated version of 'BBC-announcer-ese' — if voices on the radio did not vary in pitch and emphasis, we would soon turn it off.

It seems that neither the existing literature nor the original research in this issue<sup>8</sup> can be regarded as conclusive about these conflicting recommendations.

Most of the other recommendations by the authors may be less contentious: for instance regarding seating positions and lines of gaze; the child's need to have more time; and the helpfulness, at times, of closed questions, but these can sometimes lead to putting words into the child's mouth. Further ways of showing respect to the child can include inviting the child to contribute at every stage of the consultation: not only in explaining the symptoms (perhaps non-verbally), but also in deciding what to do next, whether it be treatment, referral, or wait-and-see. Negotiating a treatment plan with a child will increase its chances of success.

Attention needs to be paid to some special circumstances (Avril Washington, personal communication, 2007). There may be a discrepancy between the child's chronological age and developmental age. If so, it is the developmental age that determines the best communicative style and content. If English is the parent's second language, there can be a danger that the child becomes a translator or advocate for the parent, with the potential consequence that the child's needs and interests get lost in the middle of who is saying what for whom. Getting a paid interpreter for a 10-minute consultation could be unfeasible, but it may be possible to ensure that another member of the family attends who is older than the index child, and can appropriately act as interpreter.

With a chronically unwell parent, the child may at times have to act as carer for the parent. Sometimes this may be the underlying reason for the child presenting with problems. The GP may be in a privileged position through having detailed knowledge of the parent's medical history,

which can help to negotiate this particular minefield: the danger is that the child's needs may be subordinated to the parent's. Organisations for young carers may be very helpful in this circumstance.

The papers by Cahill and Papageorgiou set the skills of triadic consultation in a scientific context, but it is still an art that has to be learned, and which should be more actively taught from the first year of medical school and throughout any medical career that involves seeing children.

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## Capacity an Act in force — at last

As the playing field of knowledge between doctor and patient has become more level over the last 100 years, the law's respect for the autonomy of the patient has increased all over the Western world. Buttressed by medical views that patients exercising their autonomy tend to do better, the public have been encouraged to have less faith in the notion that the doctor knows best or that the contents of medication should remain obscure.

In England and Wales, and probably Scotland as well, as a result of the ruling in *Chester vs Afshar*, it is now the law that where a patient is not warned of a risk that should have been mentioned to a patient preoperatively, the surgeon will become the insurer of that risk because the law pretends that it is the failure to mention the hazard that has caused the damage. This legal fiction is there to enforce the autonomy of the patient, even if they would have gone ahead with the operation in any event if the risk had been mentioned. This is a rule that has been fashioned for doctors alone, as we now know it does not apply to barristers, independent financial advisers, or estate agents. Whether it applies also to GPs who prescribe medicines and fail to mention those risks that should have been

mentioned remains to be seen.

In this brave but lonely new world in which we all approach our doctors to exercise our autonomy rather than to be treated for our ailments, there is an awkward anomalous group: the patients who lack capacity to make decisions for themselves. They cannot, by definition, exercise their autonomy. Someone else has to do it for them and the question is who and by what rules.

For this group, 1 October 2007 is a historic day in England and Wales for the Mental Capacity Act 2005 (MCA) comes into force, having given us 2 years to get used to the idea. Many of the provisions are familiar, codifying what has been agreed to be the common law or best practice over the last 10 years. However, there are also some radical new features.

Detailed guidance as to the MCA's provisions is available in several forms. A Code of Practice (which is available at [www.dca.gov.uk/menincap/legis.htm](http://www.dca.gov.uk/menincap/legis.htm)) has been issued by the government. My firm has prepared a more detailed guideline to the law on Consent to Treatment in the light of the new Act which is available to download from [www.hempsons.co.uk](http://www.hempsons.co.uk).

The first crucial point is that every adult

is assumed to be capable until that assumption is displaced. The incapable person is someone who cannot make a decision for themselves because he or she is unable to understand the information relevant to the decision, to retain that information, to weigh the information, and/or to communicate the decision by reason of an impairment or disturbance in the functioning of the mind. Any of these will displace the assumption of capacity. However, the fact that someone wishes to make a decision which is plainly, in the view of their doctor, unwise is not evidence of a lack of capacity. Every person has the right to refuse treatment for good reason, bad reason, or no reason.

GPs manage the care of increasingly large numbers of patients often living at home or in shared accommodation and who, in many cases, would not be found by a court to have capacity to consent to treatment. In the future, as in the past, GPs may be able to trade upon the general assumption of capacity. However, if things go awry and patients suffer complications of treatment wherein it is found that they have not given their informed consent, the doctor is being placed in an increasingly uncomfortable position. Where the patient