Research Paper of the Year Award:

clear as a bell

A young man came in to my surgery recently with a facial palsy. Worried, naturally, and with his wife in tow to make sure that he asked all the questions to which she wanted answers. It isn't often that I see Bell's palsy, now that I'm no longer a proper (that is, full-time) GP, but my partners reckon to see one every year or two and it is so characteristic that making the diagnosis was straightforward. Neurology is stuffed with eponymous syndromes and I admire the doctors who, more than two centuries ago, were able to work out what was going on in the nervous system. Personally, the skull has always seemed a bit of a black box. Charles Bell, who described this palsy of the seventh cranial nerve, was a surgeon who left Edinburgh for London in 1812 and took over Hunter's anatomy school in Windmill Street. Roy Porter describes him as the Crown Prince of Hunterian anatomy.[1] In taking the English shilling, he also left behind a fellow anatomist, Robert Knox, whose burgeoning need for dissection cadavers infamously gave Burke and Hare their opening 15 years later.

I imagine that in his day, Bell had clear ideas about the most effective treatment of his palsy; surgeons are like that after all. My patient was no different, having been to the primary care centre, and then to his local pharmacy. The first had given him steroids; the second insisted he see me immediately to get an antiviral. The sense of urgency was palpable, as was the concern about whether he would recover. They wanted me to respond there and then, decisively and accurately. My problem was that I hadn't seen a case for several years.

That's when you appreciate the clear, reliable and memorable messages that good research can bring. In this case it was an elegantly designed and well-conducted primary care trial published in the *New England Journal of Medicine*. I changed the steroid regime to 25 mg twice daily for 10 days, told him that adding an antiviral would make no difference to his outcome and that there was an 83% likelihood he would be fully recovered at 3 months, rising to 95% at 9 months.[2]

The Research Paper of the Year looks for studies that are methodologically excellent, may have been challenging to do and address an important question for practising GPs. If they can tick all those boxes, and also deliver a clear and memorable message, they are on the shortlist. This year's winner does all of that. And my patient is very grateful.

Greg Rubin

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1. Porter R. *The greatest benefit to mankind. A medical history of humanity from antiquity to the present.* Harper Collins: London, 1997.
2. FM Sullivan, IRC Swan, PT Donnan, *et al*. Early treatment with prednisolone or acyclovir in Bell's Palsy. *N Engl J Med* 2007; **357:** 1598–1607.

DOI: 10.3399/bjgp08X319594

Top Tips in 2 minutes

As a specialty, general practice can be proud that it has led the way in helping doctors to communicate well with patients. Some of the seminal works in the field have come from within our discipline.[1–3] It is therefore perhaps surprising that recent evidence shows we are not as good as we might like to be in one area that we all encounter on a regular basis — consulting with children.

The GMC has reminded us how important it is to communicate well with children.[4] Their guidance on the matter came not *ex vacua*; rather it was developed from the mouths of the children themselves following an extensive consultation process. The GMC heard, and have reminded us, that children want us to listen to them and that they want us to involve them. Furthermore, doing so can make a difference. I was reminded of this the other day when a mother and young child came to see me with a simple wart. 'I could burn it off but it would be painful and might come back. It might be better to use some stuff from the chemist,' I told them confidently. 'That's fine,' said Mum, 'we'll head down and pick some up'. 'Is that OK with you?' I asked the girl perfunctorily. 'Actually, please could you try and burn it off? It's just that I get bullied about it at school and the quicker I can get rid of it the better.'

We can all be superficial in our dealings with children, sometimes to the point of ignoring them, but the good news is that there are things that we can do to get better outcomes, for example, giving the child the opportunity to speak rather than automatically asking the adult. Perhaps this month's Top Tips can help us to have more days when we get it right and continue our specialty's tradition of relating to our patients well, whoever they are, and however old.

Tim Caroe

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1. Silverman J, Kurtz SM, Draper J. *Skills for communicating with patients.* 2nd edn. Oxford: Radcliffe, 2005.
2. Neighbour R. *The inner consultation: how to develop an effective and intuitive consulting style.* 2nd edn. Oxford: Radcliffe, 2004.
3. Tate P. *The doctor's communication handbook.* 5th edn. Oxford: Radcliffe, 2006.
4. General Medical Council. *0–18 years: guidance for all doctors.* http://www.gmc-uk.org/children/index.asp (accessed 13 Jun 2008).

DOI: 10.3399/bjgp08X319602

Top Tips in 2 minutes: Consulting with children.

Why:

It is beneficial to the child to be involved in their medical consultation:

- A child's involvement in their own health care has been shown to be beneficial with regard to the child's health outcomes.
- Children's active participation in their own care is practical as well as empowering. As children move towards the teenage years they can take on increasing responsibility for their own health in an age-appropriate way.

It is good practice to involve the child in their consultation:

- Children over the age of 5 years old can be presumed competent to participate in health decisions. The General Medical Council, the Department of Health, and the British Medical Association advocate active child participation in decisions regarding their care.[1–3] Children should be given appropriate information to aid shared decision-making and be asked for consent as appropriate.

Children are likely to be able to speak for themselves:

- Primary school children are capable of complex tasks such as working computers, playing intricate games, and doing homework.
- A competent child may consult alone when it is necessary or if it is in their best interests.

How:

Triadic consultations:

- Consultations with children are almost always triadic: children are usually seen with an adult carer.[4]
- The adult carer is likely to have brought the child to the doctor because they have a concern.[5]
- An adult carer who has been able to voice their concerns early in a consultation is unlikely to interrupt doctor–child talk.[5]

Inviting the child to participate. Factors in the consultation observed to promote child involvement:[5]

- Seating — triangular arrangement promotes triadic talk. A child obscured by an adult inhibits participation.
- Allowing the child or the adult carer to say why they have come.
- The child is not likely to speak unless invited to by one of the adults.
- Inviting the child to speak:
  - use the child's name;
  - look at the child;
  - ensure the parent/adult can see that the doctor/nurse is looking at the child;
  - if the adult answers for the child, address a subsequent question to the child while looking at the child.
- Give the child time to answer.
- Listen to the child.

What next and when:

- Evidence suggests that children have little involvement in their consultations. They may join in social talk, greetings, giving the history, and cooperating with the examination but are unlikely to be involved in the planning and decision making parts of the consultation.[4]
- Children have little quantitative say in the consultation. Paediatric consultation studies in UK showed the child talking took up 4.2–5.42% of the consultation.[4]
- Parents/adults speaking for the child is the norm. All parties in the triad may be socialised to this position.[4]
- Children may have concerns about their health, and not all are going to want to consult on their own behalf.[5]

Patient information:

Department of Health. *Consent— what you have a right to expect. A guide for children and young people.* London: HMSO, 2001.

References/Web links:

There is a shortage of research evidence in this area:

- General Medical Council. 0–18 years: guidance for all doctors. *GMC* publication, 2007 http://www.gmc-uk.org/children/index.asp
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More top tips can be found at:
http://www.addenbrookes-pgmc.org.uk/handouts.asp?title=Primary%20Care

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Date: June 2008