

Out of Hours

Beyond patient reassurance

WHO IS BEING REASSURED?

'Patient reassured' is almost certainly the commonest concluding remark of a consultation, especially one involving a parent of a sick child. In this review of qualitative studies about parents presenting with sick children I show that what parents want and need from healthcare practitioners is assurance they are good parents and confidence they will be able to manage when they are back home with their sick child.

By reflecting on my experience of watching a trainee GP consult in a GP out-of-hours clinic, I believe that reassurance is often for the clinician's sake. The confidence building given to parents also needs to be explicit:

'Maisy's ears look fine, her throat is a little pink, her glands are a little enlarged, her chest is clear and her tummy feels fine, and her temperature is just a little bit up at 37.8. It looks like she's got a viral infection and I expect she will be like this for another two or three days before she gets better.'

I watched Keris, the excellent trainee GP describe her examination findings to 3-year-old Maisy's mum. Keris looked kind, friendly and concerned as she faced Maisy's mum, consciously ignoring the computer screen next to her. Maisy looked tired and pale and sat on her mother's lap with her head leaning against her chest. Her mum looked tired and worried. Keris noticed this:

'Was there anything else you were worried about?'

'No not really, thank you. I suppose, well you've checked her and you've said she's going to be OK.'

'If she gets any worse, or you're worried, you can always call us again and we can see her if necessary.'

'Thanks, and thanks for seeing us so quickly.'

Maisy and her mum left and Keris turned to finish typing up her consultation. She began to type, 'Patient reassured'. We looked at each other, was Maisy's mum really reassured? Was reassurance what she wanted or needed?

A series of studies looking at parents of sick children suggests that what parents want is not only reassurance — that there are no signs of serious illness and their children will be OK, but assurance that they

have done the right thing at the right time, by asking for medical advice. The articles also suggest that what parents want and need is confidence in the doctor and confidence in their own abilities.¹⁻⁴

Kai's now classic qualitative study of parents of sick children showed that they felt excluded from the apparent mystique of the professional's assessment. The commonest example was seeking advice about a child's cough when they feared infection 'on the chest' because the child's chest sounded, and even felt, 'rattly'. However, the doctor would pronounce the lungs 'clear' on examination despite apparent evidence to the contrary. Parents would then find it difficult to question the doctor's authority and were left feeling silly for worrying — or still perplexed by the problem.¹⁻⁵

Making parents feel stupid or silly

The significance of this is highlighted by Neill *et al's* study about parents' experience of criticism when presenting with sick children. Parents reported being made to feel stupid or silly in these negative encounters with health care professionals, usually doctors. They felt that they had been criticised, even when no directly critical comments were made, the criticism was communicated through the attitude or manner of the doctor concerned.³

Being made to feel stupid or silly makes parents feel guilty or ashamed, that they've wasted health-professionals' time, or that they are bad parents. The consequence of this was that parents tended to feel more anxious about their abilities to recognise and manage their children's illnesses.

Thinking back on my own experience as an inexperienced A&E doctor and an exhausted GP, particularly before I had children of my own, I have no doubts that I left parents feeling bad about wasting my time. My intention, in a rather careless, ignorant, or callous way, was to try to make sure they didn't come back with a similar problem in future. My role was conflicted between my duty to my patients and my duty to stem the tide of demand.

Parents feel in a double bind, expected to find the 'goldilocks zone' where their child is sick enough to warrant medical advice, but not so sick that they've left it too late. Doctors who make parents feel bad about bringing in sick children may believe they are avoiding patient dependency especially when the

parents don't come back, but they have done nothing to help improve parental confidence or reduce anxiety. And so, still concerned, parents take their children elsewhere in the hope of a better experience.

WHAT SHOULD WE BE DOING?

We should start by acknowledging, explicitly if possible, that parents are strongly influenced by a sense of responsibility to act as competent parents and the fear of overwhelming guilt should they fail to do so.¹ We should reassure them, not only that their child is not seriously ill, but that they aren't wasting our time and we understand their concerns. GPs are taught to explore parents' ideas, concerns and expectations, but while these shouldn't be preempted, we need to be aware that in one study, parents of coughing children worried that their children might die by choking to death, or that they might develop long-term damage like asthma.⁴ Almost all parents have experienced a child who has been listless, feverish, coughing, and miserable all night only to perk-up as soon as they get to the GP or hospital. It is far from obvious how or why this happens.

Second, the experiences of parents of sick children reveal that we need to go beyond learning about ideas, concerns, and expectations to understand informal social rules, our role as moral agents, how actual or perceived criticism can lead to guilt or shame, and how to use our own power to empower parents and other patients.^{3,6}

Third, we need to give explanations that make sense. In Kai's study, if the doctor told the patient that their child had 'a virus' or 'a bug', it was confusing, provoking anxiety rather than reassurance, and sometimes anger. Some parents believed that a viral explanation was offered when the doctor was unsure about the diagnosis.¹

Finally, we need to go beyond reassurance and give parents and patients confidence in themselves and their ability to cope. One of the reasons this is difficult, especially for inexperienced doctors is that they have to reassure themselves that the child is not seriously ill, and have confidence in their own abilities. Sometimes when we think we're reassuring patients, we're really just trying to reassure ourselves, like Keris before.

My own experience and that of other older doctors is that trainees these days have

Out of Hours Books

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more anxiety-provoking assessments, but less confidence-building experience than they used to. A recent paper suggests that anxiety impairs empathy and perspective taking.⁷ We also need to think critically about how much choice and information patients want and need because too much can worsen parents' anxiety and undermine confidence. It would be possible to design a study to measure whether parents given assurance and confidence by GPs, reconsult less frequently than those receiving 'usual care'. This may appeal to policy makers and busy GPs, but I don't think we should wait for this quantitative evidence, but act now on what we know parents want and need.

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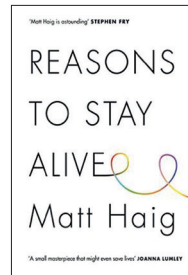
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Reasons to Stay Alive

Matt Haig

Canongate Books, 2015, PB, 272pp, £7.99, 978-1782115083



HELPING THE SAD

If reading could be prescribed as therapy, this book would earn its place in any literary formulary. *Reasons to Stay Alive* is the true story of its author, Matt Haig, aged 24 when he developed severe depression and anxiety. His remarkable story takes us on his journey from a vulnerable young man on the verge of suicide, to his tenacious efforts not to succumb to his illness, and his final self-affirming list of forty pieces of advice that show him 'How to live'.

Although it's a given that this book will benefit sufferers of depression, it is equally as beneficial to the wider public as it will help with demystifying mental illness. But the book's real strength lies in its ability to enable physicians to better understand depression: the pages are a canvas of honesty, raw emotions and, at times, chaotic and disorganised thoughts, beautifully demonstrating the endless ruminations often experienced by individuals with depression. We gain an invaluable insight into the mind of a patient with depression, a luxury which a 10 minute consultation will never afford. From the outset, Haig tells us why he wrote a book about depression:

'To lessen that stigma, and ... to try and actually convince people that the bottom of the valley never provides the clearest view.'

Time will tell whether he has achieved the former — although as GPs we ourselves can help to remove the stigma from mental illness by educating patients and their families — but he excels at the latter; his story is inspiring and an almost certain source of encouragement to anyone unfortunate enough to find themselves in despair.

To quote Haig's optimism:

'... there's a two-for-one offer on clouds and silver linings. Words, just sometimes, can set you free.'

Yes, they can.

Samar Meraj Mahmood,

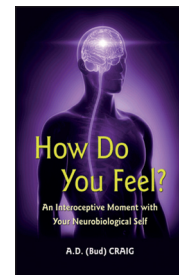
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How Do You Feel? An Interoceptive Moment with Your Neurobiological Self AD (Bud) Craig

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NEUROLOGY JUST GOT MORE INTERESTING ...

As a medical student in the 1970s I learned that there were two pathways from the body to the brain; one entered the spinal cord and ascended to the brain on the ipsilateral side, carrying discriminatory and pressure touch, and proprioception; the other immediately crossed and ascended on the contralateral side, carrying pain, temperature and something that was (very) vaguely described as 'fine' touch. Both these pathways ascended to the midbrain (thalamus) then projected to the somatosensory cortex. End of story.

Enter Bud Craig, a mathematician who strayed into a neuroscience class where they were doing single cell analysis of thalamic neurons, got hooked and changed to neurology. Struck by a number of anomalies in the explanation of these two sensory pathways from the body to the brain, he determined to work out their neuroanatomy. Fast forward 25 years and his extensive catalogue of