Current Practice

CHILD CARE IN GENERAL PRACTICE

The Paediatric Consultation

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The articles in this series are not only about consultations by paediatricians. Twenty thousand general practitioners are spending a quarter of their time on the children in their practices; so are many E.N.T. surgeons and ophthalmologists, and many local authority doctors spend all their time seeing infants and schoolchildren. The proportion done by 250 paediatricians is a tiny fraction of all consultations with children.

Most consultations are straightforward. There are two reasons for taking thought about the conduct of the consultation. One is that the more difficult consultations will require to be conducted with greater awareness of what the purposes and methods of the consultation are. The other is that there is always scope for improvement in the techniques used in our work. It is not easy to go and watch a colleague at work. But the doctor can ask a sociologist to come and watch his work and comment on his technique (see, for example, the symposium on "Parents, patients and doctors" in *Child Neurology and Cerebral Palsy*, 1960. National Spastics Society).

Essence of the Consultation

The essence of the medical consultation is, as Sir James Spence emphasized, the explanation given to the patient. The diagnosis is important as the basis of the explanation, not as an end in itself. As a result of the explanation, the patient's attitude will change and the plan for action will be implemented. These results of the explanation will, in favourable cases, lead to a resolution of the problem that brought the patient to the consultation.

Sir James's emphasis on the explanation draws attention to the fact that the consultation is not a situation involving only the doctor's mind and the patient's body but a situation involving two interacting minds, one giving an explanation and the other taking it in. It also reminds us that the consultation is not completed until the explanation has not only been given but also has been taken in, and that the doctor carries the responsibility of seeing that his explanation is indeed taken to heart—and to head—by the patient.

The first two parts of the consultation, the history taking and the examination, involve interaction between the doctor and patient. In the next part, thinking out the diagnosis, the doctor is on his own. In the later part, explanation, interaction occurs again. The conduct of the consultation indeed involves conducting in the sense of leading and guiding and also of evoking a response as the conductor of an orchestra does.

Consultation with the Child

The principles of conduct of all medical consultations apply to the conduct of the consultation involving a child. The doctor's responsibility for evoking co-operation is made more obvious because the child is less able to control overt manifesta-

tion of his feelings; his trusting smile is very rewarding and his withdrawal from contact with cold hands or a cold heart makes examination difficult. Warm hands and a warm heart will win willing co-operation.

There is at the consultation with the child a third person whose co-operation is also essential. The anxiety that is often obvious in the child at the beginning of the meeting will remind the doctor that adults, whether at a medical consultation as parents or patients, are also usually anxious even if they may not let it be so evident. The mother will be put at her ease if she is welcomed as a friend, and if the doctor wins her co-operation he will find the child does not cry and is easier to help.

Ambience of the Consultation

The doctor's task will be easier if his profession, his welfare clinic, his partnership, his hospital, has a reputation for friendliness as well as for efficiency. At a good children's hospital there is an atmosphere which conveys that its resources are all adapted to helping children. This atmosphere is conveyed by the porters, telephonists, appointment clerks, much more than by the glazed tiles of characters from nursery rhymes. Those who work in surgeries, clinics, and hospitals geared primarily to meeting the needs of adults have to take active steps to see that the special needs of children are met. The ophthalmologist, E.N.T. surgeon, and dermatologist would find it well worth while to devote special sessions to seeing their child patients.

If the places and people at the clinic are labelled clearly, the mother and child will be much more "at home" when they come for the consultation.

The arrangement of the doctor's desk or writing table, his chair, and those for the mother and child deserves some thought. Comparisons have been made of the quantity of communication resulting at interviews conducted with the two participants seated facing each other, at right angles, and side by side. Communication is greatest when the two are seated at right angles to each other, and least when they are face to face.

The doctor needs to be able to turn from his writing to make his examination, of the baby on the mother's lap, of the child at his mother's knee. The examination couch has a small part to play, though at times it is essential.

Opening Gambits

If, on arrival, the mother and child have been given a friendly, interested welcome by the porter or receptionist, they will not arrive in front of the doctor on the verge of tears. Essentially, the mother and child are guests at the consultation to be put at their ease much as any good host does with those he invites to his home for drinks or dinner. They will, for example, be addressed by name:

"Come in, Mrs. Smith, will you sit here?"

"This is the nurse and this is my secretary."

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"You are Jane? How do you do? Is that a new dress?"

"Will you tell me what it is you have come to see me about?"

If a 3-year-old looks apprehensive, the remark "there will be no needles to-day" may help him (but having said that, the doctor will, of course, have to keep his promise).

Some children are fearful of what the examination may involve and it is often worth while getting this over quickly.

"Will you take off your jersey so that I may see your tummy, please? When I've seen it you'll be able to dress up and be ready to go home. But before you can dress ready to go home you will, of course, have to take off your vest so that you can put it on again."

Examination

The infant is examined on the mother's lap; the toddler and child is examined standing at his mother's knee. Examination of the abdomen can be done well and more easily with a child standing confidently by his mother than in an apprehensive child lying on a couch. Sometimes the toddler may be laid on his mother's lap for an examination of the abdomen or for imperfectly descended testicles.

The child should be undressed. The infant will have vest and napkin removed. The older child will keep his pants on. In the undressing process there is no need for any third person, the nurse, to be involved; the mother and the doctor are enough for the child to cope with. Only if the child is very timorous will it be necessary to leave the vest on. But if he is frightened it is very rarely worth the battle of undressing by force. The older child will be asked to pull his vest off or his pants down himself. The doctor is, in a way, wooing the child to allow his body to be examined. Children and adolescents will be less puzzled by the examination of their femoral pulses if the doctor shows them what he feels.

For any part of the examination, a minute or so spent on winning the child's co-operation is well spent. The child may handle the stethoscope bell or it may be placed on his hands or on his legs or arms before it is placed on his chest. The auriroscope is shown to the child and perhaps its use demonstrated on a teddy bear. If at any stages of the examination the child is frightened and "uncooperative," the doctor has to admit that he has failed; that it is his fault. He has also to decide whether to "press on regardless" or to weigh carefully whether the additional information he may obtain justifies making the child more uncooperative at a later examination. What the doctor does to the child must always be related to the child's and not to the doctor's needs.

History

This is not the place to discuss in detail the taking of a history. Some prefer to ask what is the presenting problem and then take the history of this. Some time in the interview the doctor must offer the parent and child the chance of presenting any other problems they would like to discuss. There are two good reasons for doing this. Few patients, children as well as adults, have only one disorder, and the others deserve to be considered, for they may relate to the presenting symptom or the doctor may seize a chance of treating something early. He will therefore discuss the child's dental caries, enuresis, or acne, even if only to make sure they are being dealt with. Secondly the mother may come offering one symptom but in reality wishing to discuss something else. She may attend for the child's poor sleep when she is really worried about his slow development. Even when "Is there anything else you'd like to ask about?" has been said, the mother as she leaves the room may throw out what is to her the vital question—for example, Will it happen again with another baby? If explanation

is to be efficient, the doctor has to discover the mother's specific fear. Does what to the doctor is mild nutritional anaemia alarm her because she equates anaemia with leukaemia? "Why did the baby get bronchitis?" may need the answer "It was not your fault." It may be desirable that the child is not listening to some of your discussion. He or she will usually go outside "to be dressed" or "to look at a book."

The Child is a Person

Some of the questions will be directed at the child. He may be communicative; or it may help him if he is offered a choice of answers—"Is the pain here or here?" "Is it a big pain or a little pain?" The mother who answers for the child may be anxious that he gives the answers that are correct or answers that do not shame her; she may be a dominating mother; she may think the doctor is a busy impatient person. In talking to the child, the doctor's respect for him will, not infrequently, mean remaining at a distance and not invading the child's privacy by too great familiarity.

It is often worth seeing the child by himself, especially if he is over the age of 7 or 8, and especially if the problem seems to be one of anxiety. He may tell you fears about school that he has been unable to tell his mother, and it flatters him and may help him to the extra confidence that he needs. For a 2½-year-old, it would be more than he could cope with to be deserted by his mother and left with a stranger, but for an adolescent to see the doctor alone should be a routine and for other children it is often useful.

If the doctor takes the history exclusively from the mother, the child may well, when the examination starts, accept this invasion of his privacy because he has observed that his mother trusts the doctor, but a better history and more active co-operation are likely if the doctor has from the beginning welcomed both these guests, greeting the child as well as the mother by name.

Diagnosis

The doctor tries to make a summing up or "diagnosis" which is comprehensive in a number of ways. It will cover the presenting symptom and its underlying causes; it will include other symptoms and signs and their causes; it will include a quick review of the whole child—body, intelligence, emotions, and social environment. It will also include the "plan for action," which in relation to each problem arises out of the assessment of the symptom and its origins.

Explanation

The patients or parents come to the consultation to get an explanation of the symptoms and of what they have to do. Parents at the doctor's are anxious people; they would not be there if they were not worried. They will only be reassured if their underlying questions as well as the spoken questions are answered. And they must be answered in a way they understand. A Bermondsey mother undressed her handsome 4-month-old baby boy and said, "Is he all right?" The boy had a glandular hypospadias. I said he was a fine boy and that what she had shown me was unusual but was unimportant. She said again, "Is he all right?" so I said, "Yes, Mrs. Smith, he will pee all right and he will f— all right." "Thank God; I've been to my own doctor and two other hospitals and no one has told me."

The explanation is continued by asking, "Does that explain things or is there anything else you would like to ask?" The child should also be given an explanation: "I'm glad you're a strong chap; this cold you have is likely to get better in the next few days and then you will be able to go back to school again. Is there anything else you would like to ask me?"

It is often useful to write instructions on a card. "Between the layers of the napkin, sprinkle a heaped teaspoonful of finely powdered boric acid" or "For teething give $\frac{1}{2}$ an adult's size tablet of soluble aspirin three times a day for 3 days."

If the interview has been a stressful one for the mother she may not take in the doctor's careful explanation. I sometimes write an explanatory letter to the parents when, for example, I have had to explain that the child has cerebral palsy and is slightly deaf and is a slow-learning child.

If the news is bad, that a child is mentally handicapped or has a fatal illness, and the parents unaware and unprepared, the doctor will impart the news, not all at once, but in stages, at two or three interviews. This will take him longer, but the time thus spent is tremendously worth while, for the parents will be enabled to take in the bad news, accept it, and adjust to it.

Like all meetings, the consultation ends by "date of next meeting." The doctor will learn something of how the consultation has gone if he says, "When would you like to see me again, to-night, to-morrow, in a week, in a month, in three months?" If, with a problem that is not urgent—for example, bed-wetting—the child says, "To-morrow," the doctor may well feel flattered; if the mother says the same, her anxiety is

unalloyed and it may be wise to see her sooner than is indicated by the needs of the actual disorder.

Communications After the Consultation

The doctor will decide what letters or telephone calls are necessary. A family doctor may wish to ask the school doctor's co-operation, or the hospital for an appointment. The hospital paediatrician will write his report to the family doctor. He will also remember that every child is not only on the list of a general practitioner but is also on the list of an infant welfare or school doctor of the local authority. Both general practitioners and local authority doctors have statutory responsibilities for the care of the children on their lists, and the welfare of the child will be promoted if the hospital paediatrician sends to the local authority a copy of his letter to the general practitioner so that the infant welfare or school doctor knows what was decided.

The consultant's report after the consultation is an extremely important channel of continuing education; *bis dat qui cito dat*, and a quick report received while the problem is still fresh in the referring doctor's mind will have a much greater impact.

TO-DAY'S DRUGS

Agents for Lowering Serum Cholesterol

The best indication for lowering the serum cholesterol is found in the case of a young person with primary hypercholesterolaemic xanthomatosis who has a family history of premature ischaemic heart disease. Thorough treatment with one or more of the first four agents discussed below will often cause superficial xanthomata to regress. It is reasonable to hope that the same process may take place in any arteries that are affected.

Much more commonly the question whether or not to institute hypocholesterolaemic therapy is raised for a patient who has just had a myocardial infarction. This is a controversial issue which cannot be adequately dealt with here. The main evidence has been summarized by Oliver.¹ On the one hand, healthy people with high serum cholesterol concentrations have an increased risk of subsequently developing ischaemic heart disease. On the other hand, the results of the first two long-term trials of lowering serum cholesterol in men who had had myocardial infarction have been disappointing. This may be either because adverse effects of the oestrogens used in both trials counterbalanced any benefit from reducing serum cholesterol; or perhaps because no method of lowering serum cholesterol will improve prognosis. Thrombosis may be the most important factor determining the course once ischaemic heart disease has become clinically manifest.

However, oestrogens are now known to favour thrombosis, whereas the following four agents appear from *in vitro* tests to have some anti-thrombogenic properties. They also lower serum triglycerides, which tend to be raised in patients with coronary disease.

In following the effect of these agents allowance should be made for seasonal and menstrual fluctuations of serum cholesterol and the fact that it falls immediately following myocardial infarction and takes about four weeks to return to a steady level.

Polyunsaturated Oils

Dietary manipulation is still the best way to lower the serum cholesterol concentration. It has the outstanding advantage that it is absolutely safe. The aim should be to reduce the fat intake and replace half of the saturated fat in the diet with oil(s) rich in polyunsaturated fatty acids. The daily dose of oil required is from 1 to 2 fluid ounces (30 to 60 ml.). This regime produces an average fall of around 20% in serum cholesterol levels and reduction of serum triglycerides. The mechanism of action of polyunsaturated oils appears to be an increased faecal excretion of cholesterol as neutral sterols or bile acids.

Dietetically, it is much easier to reduce serum cholesterol by increasing the ratio of polyunsaturated to saturated fatty acids (P/S ratio) in the diet than by solely reducing the total fat intake. For comparable reduction of serum cholesterol a purely low fat diet must contain only around 15% calories as fat, compared with the British average of around 40%. This is very unpalatable and causes transient elevation of serum triglycerides. The high P/S ratio diet is at the same time relatively low in cholesterol, which is associated with the saturated animal fats. (A low cholesterol diet alone, without alteration of the other dietary lipids, causes surprisingly little reduction of serum cholesterol.)

The biggest disadvantage of the polyunsaturated fat diet is that it is more difficult to adhere to it than to swallow a few tablets. Secondly, polyunsaturated oils are officially classified as foodstuffs, so they cannot be prescribed on Form E.C.10. To the patient in the National Health Service, therefore, this cheapest form of treatment appears the most expensive. There are several polyunsaturated oils which are about equally effective in lowering serum cholesterol. They differ little in taste, so choice between them depends on cost. Corn oil or cottonseed oil or a blend of the two is the "best buy" in this country, working out to about 2d. per fluid ounce (28.4 ml.) (4d. for a day's treatment) if bought by the gallon (4.5