RESEARCH ARTICLE

Exploring parents' perceptions on the importance and feasibility of child- centred consultations of 5-11 year olds in general practice

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Abstract

Background: The active involvement of children in their health care has been shown to increase compliance and improve outcomes. Despite this, children in the 6-12 year group have little meaningful involvement in General Practitioner (GP) consultations, contributing to less than 20% of interactions.

Aim: To explore parents' perceptions on the importance and feasibility of child-centred consultations.

Methods: Purposive sampling was used to recruit parents from a primary school in London. Three audio recorded focus groups were conducted, transcribed verbatim, and subsequently thematically analysed.

Results: While most parents acknowledged the importance of child-centred consultations, they legitimately questioned their child's ability to make decisions. Parents attributed low child participation to several factors including the perceived approachability of the GP, whether their child had met the doctor before, their child's personality and the general lack of time during consultations. Parents described their own anxiety and worries surrounding their child's health care which lead to their role as their child's advocate, decision maker and protector during GP consultations.

Conclusion: This study confirms the importance of child-centred consultations and highlights numerous barriers which need to be overcome to achieve greater child involvement in consultations. If the findings were to be replicated in future larger studies, then it could lead to changes in both training and, crucially, how child-parent-doctor consultations should be carried out in general practice.

Key words: Paediatric primary care, child-centred consultations, triadic communication, general practice, doctor/parent/child consultations.

Background

According to the latest UK Census (2011), 21.3% of the overall population of England and Wales was aged 18 years or under. Caring for this large part of the population is an integral and important aspect of general practice, with the majority of general practitioners (GPs) seeing around 400 – 600 children in a typical six-month period [1] [2]. School age children visit their GPs as frequently as two to three times a year. Therefore it is fundamental that a constructive relationship between the child, their parents and the doctor is established during consultations to enable effective communication [3].

The field of triadic communication in primary care paediatric consultations is not new. Children's participation in their health care became an important subject to research and document from 1990 onwards, post the United Nations Convention on the Rights of the Child report [4]. Most children between the ages of 5-11 are likely to be able to contribute to consultations in partnership with their parents and the doctor [5] . The Health Education board for Scotland commissioned a number of qualitative studies which showed that children in primary schools both understood current health issues and were receptive to health recommendations such as the value of healthy eating and exercise [6]. Ensuring children are active members during their consultations has been shown to have a beneficial effect on treatment plan adherence and health care outcomes [7]. It prevents children from being side-lined in the consultation especially when their parent is busy in conversation with the doctor [8] [9].

The British Medical Association and all health policy guidelines now advocate that children should be involved as active participants in their health care [10]. Yet despite this, children in the 6-12 year group have little meaningful involvement in their primary care consultations, participating in less than 20% of interactions and communication [6]. 90% of paediatric GP consultations end up in a doctor-adult dyad [11].

Some studies have attempted to determine factors that influence child participation in medical consultations. Parents play a pivotal role in enhancing or limiting child participation, acting to some degree as gatekeepers for children's involvement in their medical care [12]. Considering the importance of parental collaboration in GP consultations, it is surprising to discover there is only a limited body of literature discussing parental viewpoints of triadic communication in paediatric primary care.

The main aim of this paper was to qualitatively explore parents' perceptions on the importance and feasibility of child-centred consultations. A secondary aim was to examine the factors which parents believed were affecting the degree to which their children could participate.

Methods

Three focus groups were conducted in February 2019 – two mixed groups and a group solely with mothers were carried out. Focus groups allow researchers to explore social interactions that occur in everyday life. They reproduce at a micro-level the interactions that mark the positions, ideologies and practices among specific groups of people [14].

Purposive sampling was used to include parents of different genders, ages, number of children, and frequency of their children visiting the GP (at least once in the last 12 months being an inclusion criteria). Participants were recruited from a state primary school in London's Borough of Richmond upon Thames, which according to the latest census has a population predominately made up of families with young children and older people. Noticeably, while the borough is less ethnically diverse than London, it is generally more diverse than England [13]. The first author (RT), asked permission from the school's head teacher to contact candidates via both parent mail (sent to parents/guardians of all students)

and directly when parents came to pick up their children in the school´s playground. The details of the focus groups, including dates, times and locations were included in the email and flyers.

Focus groups were conducted in the school library by the same researcher (RT), who adopted the role of facilitator, moderating the group, and used a topic guide (Table 1) for reference.

Insert Table 1 near here

Additionally, focus groups were audio recorded, transcribed verbatim after each meeting and discussed between the two investigators (RT and SS). This allowed emerging ideas to be explored in subsequent interviews iteratively. Data saturation was reached with the groups that were planned, with opinions and beliefs on certain topics being similar across the focus groups.

Focus group transcripts were analysed thematically by the two researchers (RT and SS) [13]. Both apriori codes, arising from the study´s objectives, and grounded codes, that emerged in the groups´ discussion, were used during the coding process. Once codes were developed, the constant comparison method was used to check whether the codes could be applied to the other focus group transcripts. This mix-method analysis has been described by Taylor and Bogdan [15] to comprehend a topic that is not completely disclosed; e.g. reasons for the scarce child participation in primary care consultations. The 25 higher codes were collapsed into 5 overarching themes guided by the research questions.

The data is presented by verbatim quotes and explained with the authors' interpretation and narrative. We worked to provide comprehensive descriptions of the context, sample and the participants' perspectives. The researchers maintained a running diary of the process – notes

and thoughts resulting from the adoption of a reflexive approach at all times aided the transparency and their position as researchers [16].

Results

There were 16 participants in total; 6, 5, and 5 parents respectively per focus group. The age of the participants ranged from 33 to 48 years. The number of children per participant ranged from one to seven, the frequency of participants' children visiting the GP ranged from once a month to once a year, and participants included both mothers and fathers (Table 1). All participants had completed education when they were more than 20 years old.

Insert Table 1 near here

Five main themes emerged from the data (Figure 1). Verbatim quotes are included and are coded by Focus Group (FG 1-3), Participant number (1–16), and gender (M or F). (see Table 1)

Insert figure 1 near here

1. The importance of child-doctor interactions

In general, there was an overarching positive outlook on involving children, with parents overtly acknowledging the importance of child-centred consultations.

> *'If they're young and the doctor is involving them in the conversation and asking how they're feeling, it's good for them!' (FG1, 5, F)*

Parents perceived child doctor interactions to improve compliance and increase the degree to which their children followed medical advice.

> *'I agree, the compliance is definitely improved if the GP talks to the child and explains it. My children are reluctant to take anything…. but if the GP is giving the medicine they will take it' (FG3, 15, F)*

Parents recognised that a partnership between child and GP ensured that children felt included as active members in their own care.

'I do remember once one of these doctors did try to explain to her and … she did like the fact that the doctor talked to her. She felt a bit included you know.' (FG1, 5, F)

Parents described how child-doctor interactions were important by virtue of the information their children would provide when talking with the GP.

'Sometimes children do come up with things that they haven't told you that are quite important as well, when the GP asks the questions.' (FG3, 14, F)

2. Children's ability to contribute to their consultations

The majority of parents believed that their children had the ability to contribute to conversations with the GP and the capability to answer questions directed at them.

'They have the capacity to have a conversation with the doctor and tell the doctor how they are feeling.' (FG1, 5, F)

However, parents questioned their children's ability to make decisions about their health care.

'I think they should be involved and they should be explained and spoken to, but I don't think they can truly make a sensible decision themselves.' (FG2, 10, F)

Participants felt that their child's age was a major barrier to them being able to contribute during consultations.

'I think at seven mine would be too young… I think he would probably end up making a decision that doesn't fit with the problem.' (FG1, 6, M)

There was a general consensus that the younger the child, the less able they were to be involved and contribute during consultations. Therefore, parents adjusted the degree of parent-doctor communication according to their child's age and capability.

'The younger they are you're going to be saying more, that's obvious. My younger one will not say anything; he'll just smile through the whole thing even if he's in pain... While the older one I can see he is changing.' (FG3, 12, F)

3. The effect the GP has on child-centred consultations

Parents perceived that GPs themselves played a role in facilitating or hindering child involvement.

GPs' training:

Several parents believed that GPs lacked sufficient training to involve children in consultations. Direct comparisons were made between GPs and paediatricians, with parents explaining how they thought GPs did not have the interpersonal and communication skills necessary for child-centred consultations.

'But they're a general practitioner, they won't know all the ins and outs of the paediatric world!' (FG1, 5, F)

GPs' lack of continuity of care:

Parents described how a changing GP was a major barrier for their children being involved in consultations - it was confusing and overwhelming for their children to see a different doctor every time.

'The issue is every time we go back, it's not the same GP…. You can see the child is confused' (FG3, 12, F)

GPs' personal characteristics:

Parents described how a stern or strict GP instilled anxiety and apprehension in their children, discouraging child participation.

'Her biggest worry is being told off, so a stern doctor is just, to her that's it –she'll just shut down.' (FG2, 10, F)

4. How parents view their role

Throughout the focus groups, parents viewed their role during their child's GP consultation very differently.

Parental role: child's advocate

Several parents felt responsible for supporting and defending their child – they felt that they needed to be their child's voice if they were too shy or unwell to want to contribute to the consultation.

> *'She will be really unwell and you take her and because she's scared she will say, no I'm fine, I'm fine, and she's not.' (FG2, 10, F)*

Parents felt it was their obligation to defend and protect their children.

> *'We are there as protectors. And I don't mean that GPs are going out to do the wrong thing. I just think that they are constrained.' (FG3, 16, F)*

Parental role: information conveyer

Parents viewed it as their responsibility to ensure that all the child's information in terms of symptoms, onset, sequence of events, etc. was conveyed to the GP.

> *'I often just make bullet points myself because I want to make sure, you know, that I had the opportunity to cover what is on the list.' (FG2, 11, F)*

Parental role: main decision maker

Many parents in the focus groups agreed that although their children were able to contribute and narrate the problem, decisions around treatment plans and medication were a parent's responsibility.

> *'I'm going to make the decisions on the course of action!' (FG3, 16, F)*

No parental role

A very small number of parents perceived that they had no role to play during their child's consultation. Their lack of medical knowledge and qualifications meant that their input was impractical.

'I would never expect a doctor to tell me - would you prefer this or this? The doctor has to tell me what is the best.' (FG1, 4, F)

5. The role of time in child-centred paediatric consultations

Parents viewed lack of time as a major limiting factor in achieving child-centred consultations, particularly the ten minutes given to most patients in a traditional general practice. Time was discussed across three main dimensions:

<u>Ten minutes was not enough time for a child to get involved</u>

Parents described how it took time for their children to feel comfortable and trust a doctor. The time pressure experienced during GP appointments was therefore not conducive to the formation of trusting relationships between GPs and children.

'[GPs] need to acknowledge that they probably need more than ten minutes to really get something out of the child… they need to make sure that they allow for that time to make sure that trust develops' (FG2, 7, M)

<u>Parents did not want their children to use up the 10 minutes</u>

Parents explained how they were acutely aware that they had a limited time period with the GP. There was a fear that the short time slot would be used up incorrectly by their children, so parents prioritised their own voice and version of events.

'I suspect you're trying to make your ten minutes count and it's not that, of course, the child's voice isn't important, but if you're going to get timed out you've got to, I think, make sure that you get the points across' (FG1, 6, M)

<u>Parents did not want their children to waste other people's time</u>

Parents described how they worried their child talking too much or asking too many questions was wasting the GP's time or other waiting patients' time.

'I am just conscious of time. I don't want to be wasting anyone's time so it is better if I just get on and do it' (FG2, 9, F)

Discussion

Our study's findings suggest that most parents recognise the importance of child centred consultations. Parents agreed that their children were more likely to follow the doctor's instructions when they were included in the conversations. The finding is consistent with the conclusions in the Smith and Gray [7] literature review. This states that children's minimal involvement during the management and decision making stages of consultations resulted in them having lower adherence rates to medication regimes than adults. In our study parents perceived that their children valued and enjoyed being listened to. This finding was reflected in the results from the Jordan et al. [8] systematic review, which describes how children feel ignored and side-lined when parents and GPs revert to an adult-adult dyad.

The majority of parents agreed that while their children were capable of contributing to conversations during their GP appointment, they did not have the ability to participate in decisions regarding treatment plans. This is consistent with findings in Sleath et al. [17], where audio tape recordings of medical visits found that only 13% of children asked one or more questions about their asthma management treatment plan. Parents in our research believed their children were simply too young. While studies such as that of Tates et al [18] showed that age was a strong predictor of child involvement , with younger children contributing less during their GP appointments. Nova et al. [19] used videoed recordings to highlight that children as young as two years old can understand and participate in simple conversations with doctors. The parents in our study described how they adjusted their

contribution during their child's consultations according to their child's age and ability. This differs from further research from Tates et al. [20]. They showed, rather surprisingly, from videotaped observations of over a 100 medical interviews that parents did not match their level of contribution to the ability of the child to converse in the consultation [20].

Participants perceived that a GP's characteristics, e.g. their age and personality, affected the extent to which their children were involved during consultations. Parents described how a friendly and engaging GP was more likely to result in their child participating than a stern doctor. Videoed consultations in the Tates et al. [11] study support this finding, showing that when doctors were supportive and engaging, children displayed more active involvement. Parents in our research believed that GPs lacked sufficient training specifically in paediatrics. The Royal College of GPs (RCGP) curriculum, which forms the foundation for GP training and assessment in the UK, includes a whole module on 'Care of children and young people' [21]. However this module does not include the specifics of demonstrating competency in the management of triadic consultations.

Parents in our study viewed it as their role to be their child's advocate, speaking on behalf of their child and answering questions during the GP appointment. This supports the findings in the Cahill and Papageorgiou [5] study, where video consultations showed parents frequently answering questions the doctor had directed at the child. Moreover, parents asserted their key role in making the decisions with regards to their child's treatment and medication. This aligns with Tates and Meeuwesen's study [18], where video consultations showed children contributing to consultations most during the physical examination and history taking segments, but parent-doctor interaction dominating the final treatment planning segment.

Participants considered time limitation during paediatric GP consultations to be a major factor contributing to the lack of child participation. Standard ten minute general

practice appointments are often considered too short to deal with the increasing complexity of patients' needs [22]. There was minimal literature investigating the role of time specifically in paediatric general practice consultations. Only two studies in the Cahill and Papageorgiou [6] literature review addressed this topic. Contrary to parents' perceptions of time being a barrier to child involvement, these studies concluded that when children did contribute more during consultations, the consultations were not longer, rather the parent-GP dialogue occupied a smaller proportion of the consultation.

Strengths and limitations

The main limitation of this study is that all the parents were recruited from one primary school. In 2016 Richmond's disposable household income per head was 7th out of the 391 local authorities in the UK [23] and in 2018, 67.9% of the working age population in Richmond had a university degree or above, compared to 39.2% in the UK [24]. The higher than average socio-economic status of the area was reflected in the study participants' demographics - all 16 parents left education after the age of 20, and current or previous occupations were mostly professions such as engineering, teaching, medicine or finance. The results reflect the opinions from a relatively narrow segment of the population. While parents were quite homogenous in terms of socioeconomic status, they were very ethnically diverse, with parents being Argentinian, Filipino, American, Spanish, Irish, Burmese, German, New-Zealander, Indian and English (Table 1). Importantly, some parents knew each other and each other's children, which may have impacted on the degree of information they were willing to share either positively or negatively. However, this study is unique in that it explored the field of triadic communication from a parent's perspective – a viewpoint scarcely explored in the literature.

Implications of the study

If future larger studies in this field yield similar results, this has implications for paediatric primary care. GPs in training may need further teaching on how to balance and ultimately manage the triadic nature of paediatric consultations to achieve competency and ensure consistency of standards for all GP registrars. Furthermore, practice policies could be adjusted to include paediatric continuity of care and longer GP appointments for children and their parents.

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No potential conflict of interest was reported by the authors.

Ethical consent: This study was approved by the UCL Research Ethics Committee on the 22nd of January 2019 with approval validity until the 31st of January 2020 and was registered with the Data Protection Office under reference No Z6364106/2019/01/46.

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Table 1 – Participant demographics

Focus group no.	Participant I.D.	Age	Gender	Marital status	Ethnic Group	Occupation (Current or previous)	No. of children	Frequency of child visiting the GP
1	1	42	Female	Married or in a civil partnership	White background -Spanish	Work in a school	Seven children 5,5,7,10, 10,12,14 years old	Once a year
1	2	40	Female	Married or in a civil partnership	White background -Argentinian	Sales	Two children 4 and 7 years old	4 times per year
1	3	38	Female	Married or in a civil partnership	White background	Engineer	Two children 4 and 6 years old	2 times per year
1	4	N/A	Female	Married or in a civil partnership	White background	Stay at home mum	Two children Ages not available	2 times per year
1	5	33	Female	Married or in a civil partnership	Latin American	Import and Export	One child 5 years old	3 times a year
1	6	N/A	Male	Married or in a civil partnership	White background - English	N/A	Two children Ages not available	Once a year
2	7	38	Male	Married or in a civil partnership	Asian background - Filipino	Finance	1 child 4 years old	4 times per year
2	8	45	Female	Married or in a civil partnership	White background - German	Doctor	Two children 7 and 9 years old	2 or 3 times per year
2	9	45	Female	Married or in a civil partnership	Asian background - Burmese	Primary school teacher	Two children 8 and 12 years old	Once a year

2	10	42	Female	Married or in a civil partnership	White background - English	GP	Four children 4, 6, 8, 10 years old	2 times per year
2	11	48	Female	Married or in a civil partnership	White background - Irish	Hotel Management	Four children 8,8,11,14 years old	2 times a year
3	12	43	Female	Married or in a civil partnership	Asian background - Indian	Project management	Two children 4 and 8 years old	2 to 3 times per year
3	13	44	Female	Married or in a civil partnership	White background - Spanish	Finance controller	Two children 7 and 10 years old	Once a month
3	14	44	Female	Married or in a civil partnership	White background - European	Paediatric physiotherapist	Three children 6, 8, 10 years old	2 times per year
3	15	43	Female	Married or in a civil partnership	White background – New Zealander	Physiotherapist	Four children 2, 6, 8, 11 years old	Once a year
3	16	35-45	Female	Married or in a civil partnership	N/A	Financial services	Four children 4months, 7, 9, 11 year old	2 times per year

Appendix 1 – Topic Guide

FOCUS GROUP SCHEDULE	
Before the focus group begins: - Welcome the participants into the room and ensure they are comfortable. - Build rapport with the participants – e.g. state your background as a researcher and medical student. - Inform the participants about the importance of the study. - Briefly summarise the participant information sheet and ensure they understand the information provided (this includes reminding the participants that they can stop the interview at any time and they are not obligated to take part if they don't want to). - Make sure the consent form has been signed and collected. - Explain the format of the focus group to the participants – reminding participants to be as honest and transparent as possible. - Collect demographic data from participants. - Ask the participants if they have any questions before beginning and if they are still happy to take part in the focus group. - Inform the participants that the tape will now be switched on and the interview will begin.	
SWITCH TAPE ON	
Questions	**Prompts (only use if conversation is not flowing)**
1. Let us start from the beginning. Can you tell me a little bit about your children and about their general wellbeing?	- How many children do you have? - How old are they? - Are they generally fit and well? - How often do you go to the doctor? - What are your main reasons for visiting the GP?
2. When your children visit the GP how big of a contribution do they make to decision making about their own health and to overall participation in conversations?	- Who explains why your child has come to the GP, you or your child? - Does your child correct any thing you say to the doctor which they believe to be incorrect? - Does your child seem to want to participate?
3. What do you as a parent view as your role during GP consultations?	- Do you feel it is your responsibility to relay your child's symptoms to the GP? - Do you feel that you can enhance or restrict your child's participation?

	- Do you feel that your child's age changes your role in a consultation? If so, how?
4. Do you believe your children have the capacity to participate in medical decision making?	- Do you think your children understand what is happening during their consultations? - Do you think your children are mature enough to know what is best for their medical care? - At what point/age do you believe your children are responsible enough to make decisions about their health?
5. What do you as parents interpret by triadic communication, and is it something we should be trying to achieve?	- In your eyes is triadic communication even feasible? - Do you believe triadic communication and child-centred care would improve paediatric GP consultations?
6. From a parent's perspective, what are the biggest barriers you face in facilitating child-centred care during a paediatric GP consultation?	- Are the barriers related to your children (their age, maturity, etc.)? - Are the barriers related to GPs (length of consultations, GP's personality, etc.)? - Are the barriers related to you as parents? - Is it a combination?
7. Is there anything else any of you would like to mention about your children's GP consultations?	
8. Do you have any questions you would like to ask me?	
SWITCH TAPE OFF	
To conclude: - Thank all the members of the focus group for taking part. - Explain what will happen post focus group – interview will be transcribed and analysed.	