The consultation as an interpretive dialogue about the child’s health needs

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Background. Though uniquely placed in the health care system, GPs only become aware of a small number of children with behavioural and emotional problems. Research evaluating the challenges and barriers in general practice for identifying children with problems is therefore important.

Objectives. To identify and articulate GPs’ experiences and perceptions of the GP–parent dialogue about children’s health problems, in order to broaden our understanding of the challenges inherent to the dialogue.

Methods. The GPs’ experiences and recollections were explored in a qualitative study comprising four focus group discussions and nine individual interviews. The focus of study was to explore GP consultations with children 0–5 years of age and their parent/s.

Results. Though expressing a family-focused approach to the child consultation, the GPs often did not succeed in making the consultation family focused. The analysis revealed that the GPs often were ‘stuck’ in the traditional role of expert and this made it difficult for them to explore the child’s well-being. The consultation became more family focused when the GPs moved away from the role of expert. The GPs experienced that by sharing their uncertainty with parents, they often got more insight into the child’s everyday life and family circumstances.

Conclusion. The study indicates that through open reflective dialogue the GP is able to assess the child and strengthen mutual trust in the doctor–parent relationship to the benefit of children with special needs.

Keywords. Child health services, doctor–parent relationship, general practice, qualitative research.

Introduction

It is estimated that 10–15% of preschool children exhibit behavioural and emotional problems\textsuperscript{1,2} that can have short-term and major long-term adverse effects.\textsuperscript{3,4} Although children who have behavioural and emotional problems are receiving growing attention politically\textsuperscript{5} and in medical education,\textsuperscript{6} only a minor proportion of these children are identified as having special needs.\textsuperscript{5,7,8} In countries such as Denmark, the GP is regarded as being in a particularly good position to identify the child with special needs,\textsuperscript{9} but research has shown that in fact GPs become aware of only a small number of these problems in the course of their medical practice.\textsuperscript{7,8} Research exploring the challenges and barriers in general practice for identifying children who have behavioural and emotional problems is therefore important.

GPs have been found to be particularly attentive to a child’s problems if the parents express their concerns to the GP during the consultation,\textsuperscript{8} but there are many barriers to parents recognizing problems and seeking help.\textsuperscript{10} In a study investigating family attitudes, 81% of parents believed that it was appropriate to discuss psychosocial problems with their child’s physician, yet only 41% actually did so when a problem occurred.\textsuperscript{11}

Studies have described the GP consultation as an asymmetrical interaction, given the differential in the perceived power dynamic. The asymmetry challenges both GP and parent in their dialogue regarding the child.\textsuperscript{12,13} A ‘patient-centred’ approach attempts to diminish this asymmetry by establishing a relationship of equality between the GP and the parent so that they can find a common ground in examining, understanding and managing the child’s health.\textsuperscript{14,15} While the asymmetry in the consultation may be diminished
using this approach, it remains a factor, given that it is a consequence of the purpose of the relationship.\textsuperscript{12,16}

In Denmark, the GP takes care of a child when the child is ill and is involved in a number of preventive and health-promoting consultations during the early years: three during pregnancy and seven between birth and 5 years of age.\textsuperscript{9} The GP often has all or several members of the family as patients and is responsible for referring patients to other health services. Furthermore, GPs are legally obliged to inform the authorities if they become aware of circumstances indicating that a child needs special support. Guidelines to govern and guide this aspect of a GP’s practice are yet to be established.

Little is known about the challenges and opportunities of general practice in identifying children who exhibit behavioural and emotional problems.\textsuperscript{17–19} This article draws on data from a qualitative study exploring GPs’ experiences regarding their awareness of children in need and their strategies to evaluate the well-being of children.\textsuperscript{19,20} The dialogue with the parents was essential for the GPs in evaluating the child’s well-being.\textsuperscript{19} The aim of this paper was therefore to identify and articulate GPs’ experiences and perceptions of the GP–parent dialogue about children’s health problems, in order to broaden our understanding of the challenges inherent to the dialogue and to offer insight into how best to conduct a fruitful dialogue.

Materials and methods

The GPs’ experiences and recollections were explored in a qualitative study comprising four focus group discussions and nine individual interviews. The focus of study was to explore GP consultations with children 0–5 years of age and their parent/s. Data were collected in the period June 2004 to June 2007. The data comprised verbatim transcriptions of the digital recordings from the focus group discussions and individual interviews.

Participants

Twenty-eight GPs from the County of West Zealand in Denmark participated in the study. A postal invitation to participate in a focus group interview was sent to 88 GPs who were purposely selected as representative of the county in terms of distribution of age, gender, years in practice and patient population. From the 42 GPs who agreed to participate, 4 groups, each with 7 GPs, were formed (Table 1). Nine of the GPs were also invited to participate in an in-depth interview after the focus group discussions were held. These interviews took place in the GPs’ own practices.

Focus groups and interviews

Each focus group discussion lasted 90 minutes and was led by a moderator using a semi-structured discussion guide. The first author (KL) acted as observer and note taker.

Individual interviews took place after the focus group discussions. Four GPs were selected from the participants in the first two focus group discussions and five from the next two. They were selected as representing a variety of experiences, approaches and attitudes in general practice. All GPs invited to a subsequent interview agreed to participate. Prior to each interview, but on the same day, KL spent time (how long) within the practice, observing the GP’s consultation with children and their parents. Field notes were taken during the consultations. KL conducted the interviews in the GPs’ practices, using a semi-structured discussion guide based on observations of the GP’s child consultations earlier that day.

Data from the first two focus groups and the first four interviews revealed that the GPs found the dialogue with the parent essential in identifying the child’s problems, but they also found the dialogue a great challenge in their practice. In order to further examine this challenge, the theme was included in the subsequent interview guide. The questions asked in the first two focus group discussions and the first four interviews were How do you as GPs become aware of a child with behavioural and emotional problems? How do you evaluate the child’s well-being? What are the challenges and opportunities of general practice in identifying children? The questions to the following two focus group discussions and the subsequent five

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<th>Table 1</th>
<th>Characteristics of the study participants, non-participants and of the County of West Zealand</th>
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<tr>
<td></td>
<td>Group 1</td>
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<tr>
<td>Age (years)</td>
<td>40–57</td>
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<tr>
<td>Years as GP</td>
<td>2–27</td>
</tr>
<tr>
<td>Women</td>
<td>5</td>
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<tr>
<td>Single handed</td>
<td>1</td>
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<td>Total</td>
<td>7</td>
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*Town with between 10000 and 35000 inhabitants and small town fewer than 10000
individual interviews were modified to How do you evaluate the child’s well-being? How do you talk with the parents about the child’s well-being? What are the challenges?

During the focus group discussions and the individual interviews, the participating GPs shared their everyday practice, professional and personal experiences, reflected upon and discussed these. The GPs often conveyed their experiences and attitudes through anecdotes or detailed case stories from their own practice. A total of 95 case stories about specific children were discussed. This case story data were subsequently categorized (Fig. 1).

The focus group discussion provided a dynamic method well suited to this explorative research and offered an important opportunity for self and group reflection upon complex decisions, actions and motivations. By listening to others, comparing and contrasting, participants were able to be more explicit about their own views. However, as with all focus groups, there is always a risk that the most dominant views could overshadow minority views. This potential problem was avoided through active facilitation of the group discussions, ensuring that all views were able to be aired. The individual interviews also assisted in ensuring that the GPs were able to convey their views and responses to the questions. The individual interview format was well suited to exploring in detail complex child cases and specific experiences and attitudes revealed during the focus group discussions or observed within the practice.

The study followed the principles of the Helsinki Declaration (2008) and all participants gave informed consent. The Danish National Committee on Biomedical Research Ethics was consulted; however, specific approval was not required as the study did not involve patient treatment.

**Interpretation and analysis**

Children’s well-being is characterized by significant complexity, and the interpretation of children’s well-being must be seen in relation to the context and norms of the individual child and family. Schön’s theories about how practitioners solve problems of great complexity and uncertainty provided a useful framework for understanding how GPs approached the issue. Built upon the assumption that knowledge is relative and associated with the contexts of meaning, the GP needs to be aware of the experiences and understandings of the person seeking her or his assistance. Schön advocates for a relationship of equality, whereby the doctor and the patient acknowledge each other’s particular expertise and together explore and define the health problem and subsequently agree upon a way forward. Schön sets up this model against the traditional form of practice that positions the doctor as the expert and relegates the patient to a passive role that acknowledges the doctor’s expertise, treatment and advice without dispute. This traditional form of practice works within a positivist biomedical reference.

All interview transcripts were coded in the template analysis style defined by Crabtree and Miller. Using this method, the researcher identifies text units to form the basis for theory-developed categories; for example, identifying text units in which the GPs revealed their attitudes towards parents’ interpretations of the child’s health and well-being. The authors collaborated in developing and elaborating on the themes and categories emerging from the data.

**Results**

The GPs’ experiences of their conversations with parents were contextualized within a great variety of problems (Fig. 1). Their cases demonstrated an understanding of the child’s well-being as integrated within—and relied upon the well-being of—the entire family, but they often did not succeed in making the consultation family focused. The analysis explores this finding within the framework of Schön’s two models for the relationship between the professional and the client: (i) the GP as the traditional expert and (ii) the GP inviting the parents into a reflective dialogue. None of the participating GPs practised one form exclusively, but some were more traditional and others more reflective. The cases also showed how a variety of factors influenced the GPs’ consultative styles: the nature of the child’s problems, the GP’s familiarity with the

**FIGURE 1** The problems presented in the 95 case histories described in five categories
child and the parents, the parents’ attitude and understandings and the GP’s understandings and skills.

The GPs gave many examples that demonstrated how they failed to involve parents. In these examples, they investigated the child’s well-being while keeping their findings implicit; that is, without telling the parents directly. They used a number of strategies during and after the consultation: they purposefully observed the child (and parents) during subsequent contacts; they would sometimes suggest follow-up consultations for minor ailments of a physical nature (e.g. an inflamed eardrum) to create an opportunity to see the child again soon; they asked parents in great detail about the child’s everyday life, the child’s development and dexterity and they gathered information in case notes and when possible hospital discharge letters etc. The GPs discussed their experience of uncertainty about whether there in fact was a health problem, and at the same time, they shared the common experience that such consultations could easily turn into a negative assessment, ‘something of an all or nothing scenario’ as one of the GPs put it. This took the form of either a non-specific criticism of parental competence or a tendency to take a passive and waiting position; for example:

I think it can be incredibly difficult to go in and say to these parents […] I don’t think you have been parents in a completely good way. I really think you could have done better. (Female, 56 years, town practice, individual interview).

The GPs, who were reliant upon their own observations and interpretations, were watchful but often distanced themselves from engaging with the child and her or his family. The communication between GP and parents remained an exchange of information, with scant attention to the observations, interpretations and analyses that parents could provide.

The GPs’ accounts also provided many examples of when they succeeded in their intention to make the consultation a shared responsibility. In these, the GPs shared their observations with parents at an early stage, often even before they had decided whether their observations were significant. They asked parents whether they had the same experience and whether it was of concern to them. In these examples, the GP aimed to be forthright, expressing concerns clearly in lay terms and they were specific and descriptive rather than interpretive. Often, the GPs found that when they were uncertain they would ask parents to share their knowledge and understanding of the child. In this way, these consultations became a sharing of knowledge between experts: the GPs with her or his professional medical knowledge and experience with other children and families and the parents with their specialist knowledge of the child, everyday life and their personal and family circumstances.

I also think that it is nice to say: I have something that I feel a bit uncertain about. Could we make a new appointment—and just discuss what to think about for ourselves, and then meet again? (Female, 39 years, small town practice, 4th focus group).

The preventive health examination
In the traditional form of practice, GPs accounts revealed that how they often carried out the preventive health examination without telling parents what it was about. They described how they observed the parent-child interaction and the child’s well-being, making notes for their own reference without comment to the parents and they often found it difficult to ask the parents about the family’s general well-being and functioning. They gave advice about topics such as sleeping habits and information about preventive themes without asking whether the parents wanted the advice and what they thought of it:

I know well they hear only 10% of what one says, but even so I repeat a lot of it […] I say to those parents, remember now that having fun is not sweets and video, it is much better to play hide-and-seek. (Female, 56 years, town practice, individual interview).

In cases demonstrating the reflective form of practice, the GPs purposefully used the preventive child health examination to extend the scope of what parents could talk about with them. In interviews, they described the often positive experiences they had in asking about the well-being of the whole family early on, during the first contacts with the parents during pregnancy and how during subsequent consultations they continued to build on the relationship, involving parents in assessments and drawing actively on their understanding. They said that in this way, they helped to establish parents’ trust and confidence in their GP and could ensure that parents were happy to be able to have free and open communication with them.

Families with complex psychosocial problems
In those cases in which families experienced complex mental health and social problems, the parents often had difficulty living up to the clinic’s structured system, such as making and keeping appointments. In the traditional form of practice, the GPs considered it important to teach the parents to fit into the structure. The GPs had difficulty assessing the family’s problems. They explained through the cases they highlighted that they tried to gain an overview of the family’s needs
and to plan treatment and follow-up, only to find out later that these were not followed. So they developed low expectations of these families; they became impatient and would often argue that the GP consultation was not the appropriate place to help these families and children; for example:

And it can well be that maybe I took the easy way out, but then. It is the whole time; it is every time and . . . em . . . I feel that it is no longer my job, it’s the local authority’s . . . and what are they going to do about it? (Male, 56 years, small town practice, 1st focus group).

In the reflective form of practice, the GPs understood that parents who did not keep appointments were expressing a lack of skill. Rather than educating the family to comply with the structure and organization of the clinic, the GPs tried to be flexible:

My door is still open, and I have not cancelled you. And every time you come, we will try to handle it as well as we can. (Female, 52 years, small town practice, 2nd focus group).

They took their starting point from the problems experienced by the family and not from their own understanding or perspective. They tried to gain an understanding of and respect for the parents and attempted to build trust and confidence. The GPs found that it was important first to help the parents with what they had come to the GP for rather than to give advice about care and parenting that the parents were not ready for:

“Try to respect them. […] So I just deal with the problem they have actually come with. Because in that way I can—if I can solve it, then maybe I can build up some trust. I would seldom fall over them and say: Hey, that won’t do at all; your child is not thriving. Because then we get nowhere. (Male, 43 years, small town practice, individual interview)”.

The findings are resumed in Figure 2.

Discussion

Summary of findings
The analysis of the GPs’ experiences and recollections expressed through their cases and reflections demonstrates that although expressing a family-focused approach to the child consultation, the GPs often did not succeed in making the consultation family focused. Taking a starting point in Schön’s theory about the doctor thinking and acting as an expert or inviting the patient into a shared reflection, the analysis revealed that the GPs often were ‘stuck’ in the traditional role of expert. This made it difficult for them to explore the child’s well-being. They did not ask for the parents’ experiences and understandings and continued to be uncertain about their assessment and how to communicate their concerns to parents, which kept them in a passive and waiting position.

On the other hand, when the GPs invited parents into a shared reflection and shared their observations with parents, often even before they had decided whether their observations were significant, they felt comfortable to ask parents about their experiences, understandings and interpretations. The GPs experienced that by sharing their uncertainty with parents, they often got more insight into the child’s everyday life and family circumstances. The consultation became more family focused when the GPs moved away from the role of expert.

Discussion of findings
GPs often were uncertain of how to communicate their concerns to parents, having a tendency to take a passive and waiting position. This is consistent with findings from other studies; for example, in studies of treatment of childhood obesity in general practice, 23, 24 GPs hesitated to bring the child’s obesity into the conversation because they found that parents were sensitive and often reacted defensively or denied the problem. Findings in our study advocate for overcoming the negative reaction from parents by inviting parents into a reflective dialogue, asking for their experiences and interpretations. This corresponds with the finding of Ten Have 12 and Heath, 13 who demonstrated in their studies of the delivery of diagnosis how doctors can successfully invite the patient to participate in diagnostic consideration by expressing their own uncertainty. Maynard 25 described how some pediatricians took points of reference from parents’ verbalized experiences and understanding of their child’s

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<th>The reflective practitioner</th>
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<td>Examined the well-being/health of the child without commenting on it</td>
<td>Shared his or her observations with the parent, attempted to avoid interpreting</td>
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<td>Remained observant, with a wait-and-see attitude</td>
<td>Needed and asked for the knowledge, insight, and understanding of the parents</td>
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<td>Took a position on either side of an all-or-nothing scenario: either a comprehensive criticism of parental competence or a passive, continued observance</td>
<td>Established a relationship characterising a sharing of knowledge between two experts</td>
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<td>Was mainly concerned with his or her own role and understanding</td>
<td>Attempted to understand the parent and strengthen the trust between the doctor and the parent</td>
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FIGURE 2  The GP–parent dialogue about children’s health problems in the traditional form positioned the GP as the expert, while the reflective form allowed the GP to invite the parents into reflective dialogue.
problems when delivering their assessment of the child’s intellectual disabilities. This helped the parents to listen to the doctor’s explanation and to accept a dismal diagnosis.

The GP needs the assistance of the child’s parents to assess the well-being of a child. Parents have firsthand experience from the daily life of their child. Insight into parents’ observations and experiences as well as in their understandings and interpretations give GPs a basis for greater understanding of the child’s actual problems. In situations of great uncertainty, the GP especially needs to be able to test hypotheses. When the GP is able to test hypotheses in cooperation with parents by including them in the process, parents will often be able to contribute a new or additional information regarding the child, as well as share additional interpretations.

To invite the parents into a reflective dialogue about the child requires mutual trust and confidence. Both in clinical practice and in research, the focus is more often on the patient’s trust in the GP than in the GP’s trust in the patient. In the dialogue with parents about their child, the GP needs to have trust in the parents: to trust the information provided by parents and to trust that parents will follow recommended treatment and advice. It is therefore important for the assessment of the child’s well-being that the GP makes an effort to enhance her or his trust in the parents. According to Luhmann, personal trust develops and strengthens if the different parties in the relationship dare to display more trust than they may have reason to feel. Only by risking rejection, can one create the opportunity for trust to be met with trust (ibid). It is an expression of trust in the parent when the GP expresses uncertainty and her or his need for input from the parent.

**Strengths and limitations**

The combination of methods used in this study enabled participating GPs to express their experiences, reflections and diverse feelings within the context of the group discussions while concentrating on more complex cases and themes in the individual interviews. That the focus group moderator and the interviewer in the individual interviews were both GPs, no doubt influenced the participants’ accounts and reflections. Sensitivity about being uncertain and not taking action during the consultations was expressed in confidence and with the belief that they were understood. On the other hand, the risk was that parties took certain issues for granted. The researchers met this challenge by being mindful and reflective during the interview and the analysis. To be reflective is to be conscious of the production of knowledge while it is being produced, at all levels of the investigation. KL, who conducted the investigation, was aware throughout the study of how she as a GP might influence its findings. The authors SR and PC have backgrounds in general practice and anthropology. These interdisciplinary backgrounds enabled the interpretation to be broadened from the initial design of the study to the analysis and discussions of findings and implications.

None of the participating GPs was especially engaged or trained in treating children’s special needs. They participated because they considered the research question to be important, as do the majority of Danish GPs. The study focused on GPs’ own experiences and did not assess their actual performance.

**Implications**

GPs are able to meet some of the challenges inherent in the GP–parent dialogue by accepting their uncertainty and by understanding that they need the parents’ contribute in evaluating the child’s well-being. When the GP emphasizes her or his role as the expert, it seriously hinders the exploration of the child’s well-being. If GPs want to be family focused in the consultation, they must give up their need to know the significant of observations before bringing them into the conversation.

It is important to help parents with their present concerns about the child. When GPs become aware of signs and symptoms that could indicate that a child is not thriving, it is more productive/effective if they describe what they observe without interpretation and ask the parents for their understanding and interpretations before presenting their own interpretation because parents are more likely to be open to this method of communication.

The study indicates that through open reflective dialogue the GP is able to assess the child and strengthen trust with parents and that the strengthening of mutual trust in the doctor–parent relationship works to reduce uncertainty as experienced by GPs and benefits children with special needs to be able to be identified and assessed earlier.

**Acknowledgement**

We thank the participating GPs from the County of West Zealand.

**Declaration**

Funding: Danish Research Foundation for General Practice and the Quality Development Committee of the County of West Zealand, Denmark.

Ethical approval: The study follows the principles of the Helsinki Declaration (2008). The Danish National Committee on Biomedical Research Ethics was consulted.

Conflict of interest: none.
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