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Gaining children's confidence

The judicious use of silliness

Engaging children in a clinical setting is kind to the child and their family, and is a useful clinical tool. Each of us will have our own way of getting through a child's fears and defences. Tomfoolery, distraction and imaginary play can lead to a rewarding clinical interaction.

Question: 'Why do you have a belly button?'

Answer: 'It screws in to stop your bum falling off.'

This is my standard question to a primary school child when I am poised to examine their abdomen, and it has served me well. It seems to mitigate the threat of a stranger poking at their tummy.

Engaging children in the clinical setting of one's surgery is an art; some paediatric clinical handbooks do not even attempt to teach it. Sir William Osler (1849–1919), arguably the most eminent clinician of his time, was famous for a clinical method that emphasised bedside teaching, good history taking ('If you listen carefully to the patient they will tell you the diagnosis'), and systematic examination. For children, however, one has to work around the classic clinical methods and break some rules. Osler himself would agree. In his seventieth year, while treating a child with the Spanish flu, we see him completely discard his own rigorous clinical approach yet manage to 'find out all he wanted to know' *(Figure 1)*.

As well as his humanity, Osler displays tomfoolery, distraction and imaginary play. These techniques are recognised tools in paediatric pain management[1] but they are not emphasised for use in well children in the day-to-day clinical setting. Judicious use of some silliness is useful so long as it does not obscure a central clinical aim: that the parents and child feel they have been taken seriously and that their concerns have been addressed.

Engaging children

I have been asked to reflect on what I do to gain the confidence of children. Clearly one's approach differs according to the age, illness, affect and temperament of the child and their family. In general, talking directly to a child is best – at any age. Surprising them with a few unexpected antics is disarming and allows for a fruitful clinical interaction. Establishing a playful or humorous relationship with a child lessens fear and apprehension, facilitates diagnosis and treatment, and sets up successful subsequent visits. Observing the child while playing with them or talking to parents may offer more information (eg. tachypnoea, discomfort, pain, overall development) than the laying on of hands.

Babies

I talk to babies, even in the neonatal period. 'Gooing' is not needed. Often looking intently at the baby's face and silently mouthing meaningless phrases will engage the child, ascertain their ability to see, fix and follow ('the baby whisperer'). I often hold the infant myself while talking to the parent. Initial undressing and examination is performed with the infant lying on the parent's lap. Unorthodox examination of an infant who is settled on the mother's lap, shoulder or breast will yield more information than formal examination of a fearful child on the examination couch. I have no hesitation in applying extravagantly loud kisses to the feet of an infant.

Toddlers to 3 years

Talking directly to young children in an age appropriate way often yields useful information and is enjoyable for most verbal children. It is my starting point. Otherwise, giving them toys, or paper on which to draw, facilitates history taking from the parents and then provides a talking point with the child.

I find it easier to examine small children on their parent's lap. In general, examining the child while sitting at their level or below is less intimidating than towering above them.

I pretend to examine the fingers or toes before undressing the child, simply to accustom the child to my touch. Leaping directly to the ears, chest or abdomen threatens them. Working centrally from the periphery is less intimidating. If I wish to examine the abdomen I will first ask (for children who are readily verbal) the whereabouts of nose, eyes, ears, teeth – and only then tummy. When the abdomen is exposed I palpate it, under the guise of trying to decipher what they might have had for breakfast (Weetbix? Nutrigrain?)

I will always conspicuously warm a stethoscope on my own cheek before applying it to the child. Preliminary mock auscultation or otoscopy of the parent, siblings or the child's doll enables the child to see that no harm will come to them. Otoscopy might start with transilluminating the child's fingers, which attracts their interest and demonstrates that it doesn't hurt. Ear, nose and throat (ENT) examination is the most intrusive part of the assessment and is best saved until the end.

Preschool and early primary school children

Greeting the child

I call out the child's name in the waiting room and might shake their hand without letting go, feigning to the parents that the child is the one holding on. The louder the child protests the more I stutter my claim to be the victim. Handshakes themselves can often be large and flamboyant.

If more than one sibling is present, I ask the child the name of their brother or sister and then might proceed to jumble their names.

A pillar or recess in a wall offers a chance to mock-hide from the child after they have been called in. As they walk past I will 'boo' them and instantly ask if they were frightened, feigning disappointment when they proclaim that they could see me from the start. I will occasionally usher the child into my room while unaffectedly balancing their notes on my head, or walking backward.

Talking directly to the child is usually disarming. The child will often be able to introduce whichever parent is present. On occasions I will introduce myself as being ferocious and that I can have fire coming out of my nose and smoke from my ears ('Do you believe me?') Usually I will ask the child to sit next to me ('So I can bite you if I have to'). Wrong footing the child in this way often negates the fear they might have at meeting 'a doctor'.

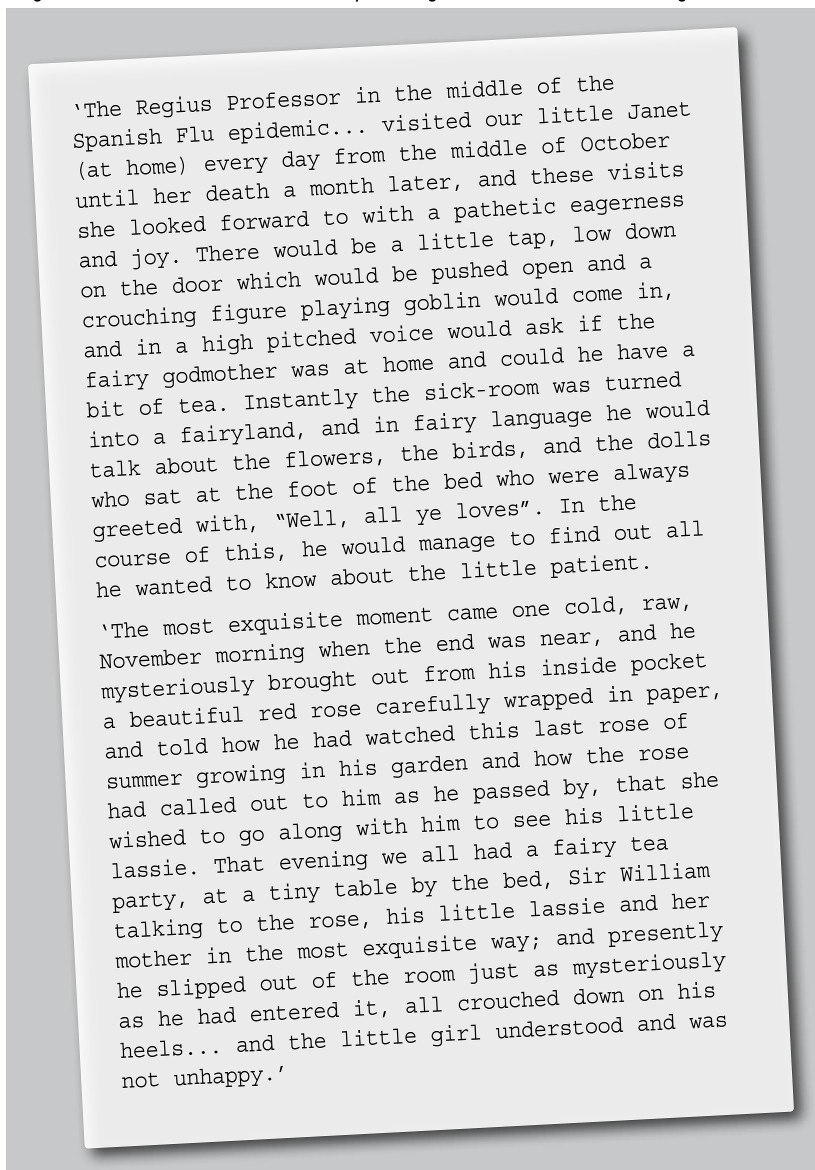
The history

Where possible, talk to the child first before taking a history from the parents, but explain to the parents that they too will get their chance. I may start by waving my hands over the child while chanting 'ooga booga', pulling at their nose or ears, or looking at their palms, then telling the child where they live (which is on the referral letter). I often pretend to read the referral letter out loud to them starting with 'Thank you for seeing this wonderful/brilliant/horrible girl', sometimes in an outrageous French accent.

A child will often be able to give a simple outline of their family. The conversation can usually be steered to what grade they are in, and their teacher ('does she bark or bite?'). I record a list of their best friends, partly to get some idea of their socialising skills and partly to be able to ask about them on the next visit by way of reintroduction. Asking about who the child does not like often reveals anxiety about school (eg. bullying).

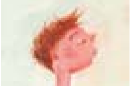
Some questions might be prefaced by a request that the child hold on to their chair 'because this is a really big question and you might fall off'. Plain speech (eg. 'peeing and pooing' rather than 'voiding and

Figure 1. Letter from a mother to Harvey Cushing on Sir William Osler treating her child[2]



'The Regius Professor in the middle of the Spanish Flu epidemic... visited our little Janet (at home) every day from the middle of October until her death a month later, and these visits she looked forward to with a pathetic eagerness and joy. There would be a little tap, low down on the door which would be pushed open and a crouching figure playing goblin would come in, and in a high pitched voice would ask if the fairy godmother was at home and could he have a bit of tea. Instantly the sick-room was turned into a fairyland, and in fairy language he would talk about the flowers, the birds, and the dolls who sat at the foot of the bed who were always greeted with, "Well, all ye loves". In the course of this, he would manage to find out all he wanted to know about the little patient.

'The most exquisite moment came one cold, raw, November morning when the end was near, and he mysteriously brought out from his inside pocket a beautiful red rose carefully wrapped in paper, and told how he had watched this last rose of summer growing in his garden and how the rose had called out to him as he passed by, that she wished to go along with him to see his little lassie. That evening we all had a fairy tea party, at a tiny table by the bed, Sir William talking to the rose, his little lassie and her mother in the most exquisite way; and presently he slipped out of the room just as mysteriously as he had entered it, all crouched down on his heels... and the little girl understood and was not unhappy.'



defecating') should be used. For noisy or uncooperative children, whispering my questions or instructions to them 'as a secret' will often get their attention as my co-conspirator.

Examination

Generally I find it easier to perform an initial examination with the child seated either on the parent's lap or on their chair. Later, if needed, one can direct the child to lie on the examination couch. I conspicuously count the child's fingers or toes and then ask the child to guess how many they have. Invariably, if I'm reaching for my stethoscope it is so that 'I might pretend to be a real doctor'. I often auscultate the child's nose or ears, pleading that 'I was away the day we did stethoscopes'.

Older children

Talking directly to the child is vital. The older the child, the more readily one can use orthodox clinical methods, although some silliness may be helpful so long as it is not seen as disrespectful or dismissive. I will usually see adolescents with their parents initially but at some stage in the first interview I try to see the child alone.

Conclusion

There is no single way to engage a child – it is a part of the clinical interaction that is not given to regimentation. A small amount of silliness and playfulness used judiciously often goes a long way. For those like me who are embarrassed discussing such flummery with one's peers, have no fear of using it with children you treat. Osler would approve.

Conflict of interest: none.

References

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