Personal practice

Hospital teachers: medical interpreters or raffia mafia?

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Doctors as educators

Is it desirable that ward teachers, many of whom have been on the same ward for several years, should help out if the ward is short staffed by taking children's temperatures or monitoring their blood pressure? It is easy to imagine the outcry there would be if someone made that suggestion seriously. Arguments would speedily be mustered to show that these tasks, although not complex in themselves, are the proper professional concern of those who have been trained not only to perform the task but to understand medical theory. It is probable that no amount of counter arguments about the efficacy of 'on the job' training and the value of general experience in dealing with sick children would be deemed sufficient to persuade the medical profession to hand these procedures over to teachers, however capable and well motivated those teachers might be.

In contrast, every day in hospitals many doctors, some of them relatively young and inexperienced in communicating with children, attempt to explain to children, in a reassuring way, complex information about body malfunctions. They rarely have time to ascertain whether the child has the necessary grasp of how a well body functions that would enable them to understand the information they are trying to convey, and they may have only a vague notion of the way in which children's cognitive abilities develop. They may attempt to illustrate their exposition by a quick drawing on the back of an envelope or there may occasionally be a typewritten sheet explaining specific procedures given to parents.

On the whole it seems to be accepted that doctors should be expected not only to be able to perform certain medical procedures but should be equally able to explain these lucidly and at sufficient length, with diversions into teaching a basic biology syllabus

as necessary, to children of all ages and abilities. If they unaccountably fail in the latter task then parents, in an unfamiliar environment and handicapped by anxiety about their sick child, are expected to glean enough information to enable them to prepare adequately the child for whatever procedures are necessary. If teaching children really were so easy it would hardly be thought necessary for teachers to study for several years and to complete a probationary year before being deemed competent to undertake the task. Equally, if learning were so easy all children would remember everything they were told and we could say goodbye to all educational measuring devices from spelling tests to finals.

Childrens' encounters with hospital

Hospital teachers fortunately are not expected to miraculously acquire medical skills but it seems that many hospital doctors are forced to try to give themselves an in service course on teaching children. There may, however, be ways to develop interprofessional cooperation between doctors and hospital teachers that would make sense as a teaching strategy for most children who are in hospital for very short stays and which would also provide busy doctors with ready made educational materials to aid their communication with child patients and their families. This is not a problem confined to a few children. Statistics show that an encounter with a hospital is a normal part of childhood for many children. Unfortunately many children fail to gain all they might have done from the experience and at worst the encounter leaves the child with profoundly negative feelings about hospitals and doctors.

A quarter of the British child population will spend at least one night in a hospital before 7 years of age, and many more will visit accident and

emergency departments.^{1,2} Once admitted to hospital children (and their parents) will encounter many new and baffling experiences. It is certainly the case that apprehensions and fears are the frequent companions of illness, but for children in particular a stay in hospital is especially traumatic. Their concepts of illness and their interpretation of the meaning of medical procedures are emotionally laden. They have fears of abandonment and lack of control and young children often interpret the illness itself and the process of medical treatment as punishments for moral or social transgressions. They often have distorted ideas about their illnesses and suffer from disturbed fantasies involving mutilation and death, even about so called minor operations.

It is remarkably easy for health care professionals to forget how upsetting even the simplest aspects of hospital are for the layman. They fail to appreciate that for the patient a hospital admission is a special event fraught with anxiety. Confronted by strange faces, strange food, and a strange routine, alone in a potentially threatening environment ignorance intensifies the feeling of being helpless in a hostile place. Even the simplest procedures in these circumstances become an ordeal. Really caring professionals would do well to remember that the patient's definition of a minor operation is one that is performed on somebody else. For a child the potential psychological trauma inherent in a hospital stay for even relatively 'minor' surgery or treatment may be a high price to pay for improved physical functioning.

The medical profession has obviously been aware for a considerable length of time that hospitalisation and surgery can create a series of real or imagined threats for a child. The goal of ward management programmes is usually described as the restoration of physical function and mental well being while at the same time preventing residual psychological and somatic problems. In order to accomplish this doctors should regard psychological trauma accompanying surgery as a complication as deserving of their thought as post-operative bleeding or infection.

Avoidable stress

Tireless campaigning led to the recommendations contained in the Platt Report (1959) that the sick child's needs for his mother, for play, education, and as far as possible a normal routine, should be met in hospital.³ The pressure for a child and family centred philosophy of care has been maintained by groups such as the National Association for the Welfare of Children in Hospital (NAWCH). As a result, for many sick children one of the primary

causes of distress in earlier times, separation from their parents, is no longer an inevitable consequence of a hospital stay. Other equally avoidable stresses, however, still remain part of a stay in hospital for too many children.

The permutation of factors that affect the outcome of a child's stay in hospital, making it a constructive or a traumatic experience, are endless. Research has shown, however, that over and above the effects of the presence or absence of parents there remain other causes of emotional distress, many of which may be avoidable with adequate planning and resources. A simple example is the way in which the physical discomforts of pain and illness are further compounded by an unfamiliar institutional setting, while comfortable child oriented surroundings help to lower the child's anxiety and make him more amenable to examination and treatment. In addition, lack of understanding of illness, hospital routine, and medical procedures can all contribute to a child's emotional disturbance.

Appropriate psychological preparation for hospitalisation and surgery combined with supportive care can mitigate the stress experienced by patients. This has been an assumption underlying many clinical practices for several decades. There have been several studies that have concluded that children who are prepared for a stay in hospital and for hospital procedures display less emotional disturbance than those who were not. It has also been shown that it is more effective if this preparation can be given to both parents and children, particularly at what Vinstainer and Wolfer termed 'stress points'—for example, admission, blood tests, and the time before and after surgery.⁴⁻⁷

Unfortunately this takes a considerable amount of time. Busy medical and nursing staff may end up doing no more than paying lip service to this ideal, and with the increasing complexity and efficiency of modern medicine there is the danger that patients may be treated more and more as bits of machinery brought in for repair. Most doctors would strenuously deny that they did not communicate adequately with patients or their families but of all the criticisms levelled at doctors the most common concerns their failure to tell patients the things that they want or need to know. Fletcher and Robertson concluded that the difficulty parents have in getting enough authoritative information about the treatment, progress and aftercare of their children is a 'common and well-founded complaint.'^{8,9}

Barriers to effective communication

Even those doctors who do make valiant efforts to

convey information to patients or their families are likely to underestimate the problems arising from their lack of a simple common language with a shared meaning. They may not realise that patient's ideas about human anatomy may be quite bizarre and that knowledge of the simplest concepts of physiology may be totally lacking. Boyle found that there was not 100% agreement among doctors in one hospital on definitions for simple medical terms or in choosing the site of the heart on an anatomical diagram! Small wonder that he found that patients did not reach agreement on definition for any term. He suggested that clinical investigation had simply verified his impression that there are large areas of misunderstanding between conventional medical opinion and what he charmingly termed 'the vagaries of the lay mind'.¹⁰

Friedson has suggested that communications between doctors and patients break down because of the doctor's professional contempt for the patient's ability to enter into informed cooperation with his consultant.¹¹ It is proposed that this is the dominant professional's way of maintaining his prerogative to diagnose and forecast illness and that while he does not want anyone else to give information to the patient he shows a considerable disinclination to do so himself.

Even if one takes a less cynical view of the current system of hospital care, the odds appear to be stacked against effective communication between physicians on the one hand, and children and their families on the other. In modern hospitals communication problems are compounded by the fact that doctors and nurses see the children in their wards for very short periods of time. Pill found that the average amount of time the nursing staff in a hospital ward spent with each child was just 28 minutes, most of this time being used to perform routine tasks rather than fulfilling the child's emotional needs.¹² It is not then surprising that MacCarthy, in his study of communication between children and doctors, remarked 'It is a sad admission that on the whole paediatricians have very little relationship with children in the sense of a one-to-one confidential relationship'.¹³

Teachers as interpreters

There is usually someone in the children's ward, however, who may well have this sort of relationship with each child and who spends a considerable amount of time working with them and their families. The ward teacher is trained for several years in the art of communicating with children and is well used to breaking down all kinds of complex concepts into manageable bits of knowledge.

Teachers will never assume that just because children have been told something once, twice, or six times that they necessarily understand it. Well inured to classroom howlers they may be more ready than the most eminent paediatrician to deduce that a child may have construed 'oedema in the stomach' as 'a demon in the stomach' thereby suffering unnecessary terrors.

In a totally alien environment the teacher is the one professional who has a common frame of reference with the child and who belongs to the child's everyday well world. Unlike other adults they meet in the hospital, children can make a reasonable guess at the sort of demands this person will make on them and can be totally confident that at least here is one new found friend who—unless it is a sewing lesson—is unlikely to start advancing upon them with a needle!

Hugh Jolly pointed out that a child's hospital stay should be able to offer more than the prime aim of helping them to recover from an illness. He contends that it should be orientated so that the child learns as much as possible from the experience.¹⁴ His, and my, view of the ward teacher is not that of some anonymous ward fixture, trailing raffia and incomplete jigsaws, but rather someone who is a 'specialist exploiting the potential of the hospital environment.' Helping children to interpret and evaluate experience is not just a part of the hospital teacher's job, it is something all teachers do. In the threatening, unfamiliar hospital environment this aspect of the teacher's role assumes a particular importance.

The hospital teacher's role, however, could extend well beyond this and they could also offer a valuable service to the medical profession in providing written 'user friendly' materials that deal factually with basic physiology, hospital procedures, and routine. Before more conservative readers throw up their stethoscopes in horror may I say that we have already begun to do this in Newcastle with the active cooperation of several departments and the results to date have been very encouraging. We have developed worksheets that aim to use the unique hospital environment as a teaching opportunity. The format of the sheets vary but they include information, quizzes, and suggested activities that are aimed at children. The worksheets are printed and use photographs of hospital personnel and technology. As they are not obviously 'kids stuff' some of them are also acceptable to many adults. Although this spillover into adult education was envisaged at the outset, we had not expected that this would include a request from one director of nursing for copies of our sheet on 'How A Gamma Camera Works' for her nursing officers!

The sheets are produced in close consultation with the department or professional concerned. Drafts are sent back and forth between our service and the department or consultant involved until they are completely happy with the information they contain. In some cases the worksheets then go to that department and they control their distribution. The Hospital Teaching Service is merely acting as a 'translation service', helping to put across this information in a form children and their parents can readily comprehend.

Interprofessional collaboration

Despite the apparent benefits of someone transcribing in simple terms what a good physician would wish to convey to a child and their parents so that it is available for consultation at leisure, some persuasion has been necessary to allow us to offer this service. Our attempts to initiate this kind of cooperation are not always greeted with universal delight. Occasionally it is difficult to decide whether this stems from the medical profession's defence of the exclusivity of their 'high status knowledge' or genuine fears that information will raise rather than alleviate patient stress. As educationalists simply attempting to offer our specialised services to professionals with a different orientation it has sometimes appeared to the vagaries of this lay mind that in some branches of medicine three consultants gathered together provide at least five shades of opinion.

Some medical colleagues maintain that each doctor works in such an idiosyncratic way that it would be impossible to produce a worksheet everyone would be happy with. One would assume that the general layout of normal skeletal, digestive, or circulation systems can hardly be a matter of contention and in fact form part of general biology courses in schools so there can be no logical objection to teaching these in hospital at a time when they are of particular interest to the child. Those worksheets that use a particular physician's approach, which may in part differ from that of his colleagues equally present few real problems. We are quite happy to produce 'one off' versions for use in different wards while the distribution of highly specific information is in the hands of the departments concerned. It is hard therefore to see how this kind of collaboration in the production of teaching materials presents any threat to the doctor or patient. Although there may well be many areas of medicine where doctors may feel the service we are offering is inappropriate, there are surely many more where instantly available information prepared to each department's own specifications

would greatly ease the physician's difficulties in explaining to patients exactly where the offending organ is situated in the body, how it works normally, and what they intend to do to put it right.

It is elitist and illogical to try to maintain an illusion that medicine and surgery are some kind of esoteric mysteries and that the preparation of teaching materials could not be done by other professionals with more time and more expertise in the field of child communication provided they receive adequate information and guidance from medical personnel. Has it ever been suggested that science teachers should be qualified nuclear physicists before they are allowed to explain to children the principles of nuclear fission? While it is obviously important that it is the doctor who explains the abnormalities in functioning that have landed the child's body in hospital, it is not necessarily a doctor who can best explain to a confused and frightened child how normal body systems function, although they and their parents need this information in order to put into context what they are told by their doctor.

Although Vaughan was sure that 'a short while in a hospital ward cannot help but make one appreciate that much of what is said to children (and for that matter to parents also) is beyond their intellectual grasp, particularly if they are anxious and in strange surroundings',⁵ even the most aware paediatrician may forget that it is not enough for a child to be told a fact once or twice—it has to be assimilated. The blame for this lack of understanding does not lie entirely with doctors. Many studies have shown that after routine consultations the average patient remembers only half of what he has been told, and others record that even when special care was taken to provide full information as many as a third of the patients forgot what they were told and thought that they had never been told it.¹⁵

The role of parents

It is important to remember that it is not only the children who need to know what is going on. Research has shown that information given to parents is usually deficient in both quantity and quality even though in reality it is the parents who are generally addressed in any consultation with a child, even older children being 'routinely and smoothly excluded from the bulk of the action within most consultations'.¹⁶

It is essential for parents to have accurate information otherwise they will not be able to prepare their child adequately and the stress of their own ignorance may result in 'emotional contagion' from the worried parents further distressing the sick

child. Pious medical belief that parents will ask busy doctors about anything they do not understand contrasts with the parent's view that despite the air of 'deliberate jollity' on ward rounds it was so rare for doctors to volunteer information that parents felt it was 'somehow deviant or indecent to ask for it.'¹⁷ The root of this problem lies not in the nature of doctors or of patients but in the hurried conditions of hospital work. As this situation seems unlikely to improve in the foreseeable future it is even more essential that the medical professions take advantage of all aids to communication with patients that may be on offer.

There is a need to produce more materials and activity sheets for parents and children to work on together. These can reduce stress from potentially threatening events through the communication of accurate information about the event. Such material provides the child with a cognitive framework within which he can appraise the potentially frightening and disturbing events that will be experienced and will set the scene for an imaginative mental rehearsal in which 'the work of worrying' can take place.'¹⁸ To truly understand something unknown and fearful a child needs opportunities to come back to it in his own time.

Ignorance is not bliss

Many, if not all, doctors used to believe that it was bad for patients to know too much about their illness but one thing is certain, if such information is withheld or given inadequately by doctors the child does not go through his hospital stay in a blissful ignorance. To an ill patient no news is not good news. It is an invitation to fear and the fears in fantasy far outweigh and are more terrifying than any reality-fears could ever be.¹⁹ If adults dismiss the idea that children in hospital are often anxious or sad and that these feelings can have far reaching effects, they may well be resorting to a kind of 'functional blindness' by which they spare themselves an acute awareness of children's mental suffering that they feel powerless to alleviate. In practical terms the child's negative feelings can transform themselves into anticipatory anxiety before actual medical procedures; this can result in a lack of compliance during treatment and lead to a protracted and difficult readjustment.

Properly designed preparation material used by parents with their children before medical procedures can considerably alleviate the effect that high anxiety on the part of the parent can have on the child's apprehensions. 'Prepared' children are clearly less anxious and more cooperative than 'unprepared' children. Even where there is apparent

agreement that children should be told what is going to happen in medical procedures, however, excuses are still made for not giving this information. Professionals cite lack of time as the reason, and parents and teachers feel they do not have adequate information to do the job properly. Meanwhile children continue to suffer needless fears and develop negative attitudes to hospitals, doctors, and health care.

Conclusion

Almost every situation has within it the potential for growth, and health care encounters are no different. They need not be purely traumatic but instead can be constructive learning experiences. If a child and his family are to gain maximum benefit from a stay in hospital it would seem that an important and easy way to help this would be for hospital teachers and medical and nursing staff to enter into active collaboration to ensure the patient has adequate information in an easily assimilated form. Although children may still find it difficult to welcome the prospect of a hospital admission, at least some of the unnecessary traumas will be removed and we will be closer to observing Florence Nightingale's dictum that 'The very first requirement of a hospital is that it should do the sick no harm.'

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