I am a child, but also a being...

– Dr Hélène de Kok

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PO Box 231
Gobabis
SWA/Namibia

Curriculum vitae

Hélène was born, bred and matriculated in the Vrystaat. After doing a BSc she taught Maths and Science in the OFS, Rhodesia, London and Zambia. She decided to take up Medicine as this was the only field where there was equal pay for equal work. Since qualifying she has been working twice as hard to prove the point! In 1974 she retired to marry Boetie Claasens, a cattle farmer in North Eastern Namibia. The retirement was of short duration as she started a bush practice on the farm, which is 80 km from the nearest hospital. The patients come on foot, by horse cart and sometimes in five ton cattle trucks. Her medical interests are Paediatrics, Emergency Medicine, Community and Family Health.

Summary

Children have their own personalities and their own specific fears; the only way to get them to cooperate in the doctor's surgery is to respect them, communicate with them, be absolutely honest and explain what you will be doing and why. A few personal experiences illustrate this.

S Afr Fam Pract 1990; 11: 548-50

KEYWORDS:
Physician-patient Relations; Child; Fear; Communication.

"If you don't care about the children, you don't give a damn about the future..."[1]

Over a period of almost fifteen years, I have time and again been amazed by the quiet and co-operative, almost mature attitude of most of my small Herero patients. I have also repeatedly wondered at the stoical reaction of Bushman infants even to the most painful injection. Why do they react so differently? Is there a novel or unusual approach of the parents in handling these children?

The majority of the patients were Hereros (85 to 90%). There were also Bushmen, Afrikaners, Coloureds, Nama's, Germans, Tswana's and a few English and Ovambo.

I started listening and watching and learnt a few basic maxims that have perhaps become a little blurred in our hurried, scientific world.

(For "him" also read "her" throughout).

The essence of the entire approach is distilled in the first maxim.

1. *Communicate with the child.*
2. Establish a trusting relationship.
3. Identify the child's problem – doctor/hospital?
4. Respect his privacy.
5. Explain your intent.
6. Treat them with absolute honesty.

The principles sound so basic that we all probably feel that we follow them exactly.

They also apply equally to adults, and are perhaps used a little more often in adults. We tend to negate or forget the child's rights as a person, albeit a very small one.

1. Communication

To establish contact with the child, any 'language' that the child understands, that is acceptable to him and that is also determined by his age, can be used. The Herero parents invariably murmur to the children during the examination. It is not the content that is important, but the gentle manner and the calm, placatory tone.

One sees the exact opposite in perhaps more sophisticated, maybe more educated or just Westernized, handling of some children. The parents may approach with an already cowering or tearful child – the exact counterpart of the previous one. This is also manifest in the handling. They shout at him, slap him, shake him or threaten him!

Afrikaans parents from this rural and

... I am a child

rather isolated area took their small son to a large city in the Republic for a tonsillectomy. The surgery was excellent; the anaesthetic very safe and proficient.

The small boy, who was in a totally strange city, had been transplanted from his safe, familiar existence into a completely different, unknown environment. He was grabbed at the theatre door from the arms of his mother. The anaesthetist, who knew that he was from South West Africa, made no effort to communicate with the child. He immediately commenced his very efficient administration of the anaesthetic. He did apparently ask the child's name.

> The quiet, almost mature attitude of my small Herero patients

What a traumatic experience for the poor little fellow. What a difference a little communication would have made!

When the parents enquired about this later, they were told that the doctors would not complete their theatre lists if they made conversation with the patients!

Is it that homo sapiens have become subject to such servitude, succumbing to the slavery of Mammon?

2. Establishing a trusting relationship

By sympathetic communication, a trusting relationship can be fostered with the child and the parents to the mutual satisfaction and advantage of both parties. This will most probably be of an enduring nature.

3. Identify the child's problem or fear

This usually originates from a previous traumatic experience where the child was treated unsympathetically; was handled roughly; was threatened with an injection or hospitalization as punishment; (this has occurred in the surgery in my presence frequently!) or where no explanation or a dishonest one was given to the child. The possibilities are numerous.

The parents of an eight year old boy came to me in despair. I was doing a locum in the Karoo at the time. The child had absolutely, completely and consistently refused to have dental treatment. He also refused totally to have an anaesthetic. The despairing father said that the holes in his teeth were as large as craters. (As another patient once said to me "... hy het holle in sy tande").

> Communication is the essence

I asked to speak to the terrified child and said to him: "Are you afraid of an injection?"

He obviously answered yes.

"Well," I said, "I promise you I won't give you an injection."

He consented, having no reason to disbelieve me. The anaesthetic was given inducing him with a mask. To the eternal gratification and surprise of his parents the procedures were successfully completed. They repeatedly asked me what I had done and how I had done it.

The child's own specific fear had been identified and annulled.

> It is not the *content* that is most important, but the gentle and calm *contact*

The fears of the children may be varied. They are probably conditioned by previous contact or experience with a "medic". They may seem of no consequence to you. But if you can identify and eliminate them, the child will become much more co-operative.

4. Respect their privacy

In many cases there is not only fear of the doctor, but also fear of an intrusion into his privacy; and assault of himself; a desecration of his body image or encroachment into his body space.

Often the mother sits down with the child on her lap and yanks up the shirt or little dress, with no preliminary warning or explanation. The child will react according to his own small personality. He may dissolve into tears, explode into screams of fear or anger, thrust the stethoscope away with an aggressive movement or succumb to modesty and cover up with great zeal. He may give you an admonitory look as if to say ... my private parts are MY private parts, even though very small. This although you may think a three-

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or four year old has no cause for modesty.

Get him on your side by communicating gently and sympathetically and he may even consent.

5. Explain your intent

This may seem an entirely unnecessary maxim. Yet I often remember this in the midst of a very hectic morning, when I thrust the cold oroscope into an unsuspecting infant's ear and he responds with a roar of angry surprise and mortification. How different is the outcome when you approach calmly and quietly and first say in a soft, soothing voice something about ears in his own lingua. This applies equally to feeling a tummy or listening to a chest.

Children are excellent mimics and they revel in a comic situation. I very seldom fail to have a clear vision of the back of a throat by demonstrating

> Get his own consent to uncover him

rather grotesquely on myself with the torch shining on my capped teeth and down my own throat. This does not add much to my dignity, but dignity seldom concerns children.

6. Treat them with absolute honesty

Children have an uncanny knack, born perhaps from necessity, of seeing straight through guile. No subterfuge, however slick, is subtle enough to bluff them. However polished your veneer, they strip it off you. They are also basically logical, not having yet been side-tracked by irrelevant issues. Treat them with absolute honesty, and they will respect you and establish a trusting, confiding relationship with you.

There is no sense in telling a child an injection won't hurt, when you damn well know that it does! Next time he won't trust you, nor will he believe you. There is a much better response and a more fruitful relationship if you say perhaps: "The injection does hurt, but it makes you better. You may cry, but you are so big, I am sure you will only cry a little."

There is the difficult, grey area of the child whom you first see through the open doorway streaking down the dusty road with a few relatives in hot pursuit. He claws and kicks and shouts. He comes into the surgery with his eyes screwed tightly shut, screaming at the top of his voice. No effort at contact, no soothing voice or mimic can reach him. He sees and hears nothing.

Here, making use of the herd instinct pays off in my practice. I bring him in with two or three others, and then totally ignore him, while employing all the principles in attending to the others. Usually by the time that his turn comes, there is at least a gap to get through to him.

A small boy, named after the great Greek, Alexander, came with his parents into the surgery. He was well-clad, very quiet and watched me with immense concentration from under lowered lids. When I went into the next room to examine his mother, there was a cascade of chattering with his father, a rapid and voluble burst of words. The moment I returned there was total silence. This happened a few times.

I asked the father what he was saying.

The child did not think that his illness warranted an examination by me, definitely not an injection. He

> …"Doctors would not complete their theatre lists if they made conversation with patients"

did think that he needed a little cough medicine. He felt decidedly insecure.

When I finally came from the adjoining room, I said to him in his own language: "Do you need a little medicine for your chest?" He silently and tentatively nodded assent. I then asked him whether I could listen to his chest. He nodded again – still not having spoken a word in my presence. And he still watched me unwaveringly.

I then handed him a bottle of cough medicine and at last he spoke to me, in his own language. At last he now also looked me straight in the eye.

"The two of us, you and I, will meet together again," he said.

I regarded this as a great vote of confidence. There was an expression of trust and a commitment to a relationship.

Quotation:

1. *Dr Don Rae addressing WONCA Congress Jerusalem (June 1989).*