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Title:

Communication skills with children for paediatric anaesthesia - challenges while wearing a face mask

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Abstract:

Communication with children in the context of anaesthesia provision is a skill, the importance of which is especially highlighted by the COVID-19 pandemic and the ubiquitous wearing of face masks. Anaesthesiology consultants have been shown to display excellent communication skills that facilitate the development of rapid rapport and patient cooperation. Good communication results in positive interactions for hospitalised children, which correlates with improved health care outcomes. However, interactions with a child aren't always straightforward, particularly for trainees unfamiliar with certain communication techniques, which are important to utilise at a time when when the wearing of facemarks is commonplace.

Main text:

Communication skills with children in the context of anaesthesia provision is a skill, particularly when it comes to induction of anaesthesia. For the uninitiated - namely, anaesthesiology trainees stumbling into their first rotation in paediatric anaesthesia - interactions with a child aren't always straightforward. Indeed, plans for a smooth anaesthetic induction can be scuppered in the blink of an eye. You might shrug and say "you win some, you lose some" but positive interactions with a child when they visit the hospital are important. Studies suggest that good communication skills correlate with improved health care outcomes (1, 2). Anaesthesiologists have been shown to display excellent communication skills that facilitate the development of rapid rapport, cooperation and trust with the patient, especially so in the setting of induction of anaesthesia in children (3). It is thus worth considering how such communication skills can be developed in those stepping into the world of paediatric anaesthesia for the first time.

Induction is the transition from the awake to the anaesthetised state, and can be gaseous (involving the child breathing the anaesthetic agent through a mask) or intravenous (if the placement of a cannula can be negotiated). Unlike the usual doctor-patient dynamic we encounter in theatre, this particular interaction usually comprises three members: anaesthesiologist, child and parent. For some, this can lead to a heightened degree of communication difficulty. Discerning non-verbal cues, managing child-parent dynamics, addressing the child's concerns, diffusing parental angst and worry, selecting the best negotiation tactic, all while planning and delivering an anaesthetic - it takes perception, skills and time to perfect.

From direct observation, I recognise that some anaesthesiology trainees can struggle to effectively engage with children during their clinical rotation. Mis-firing chit-chat can lead to a laborious and stressful induction for anaesthesiologist, child and parent alike. The stress that often accompanies induction can be reduced, however, through good communication (4). Anaesthesiologists usually learn their communication skills through modelling of peers, and then develop these skills over decades of clinical interactions with children and their parents (2). This too was my experience - pay close attention to what the consultants do, and follow their example. In fact, most health professionals feel that experience rather than academic coursework has taught them the necessary skills and techniques for communicating with children (5).

Reflecting on my paediatric anaesthesiology rotation, I see that the development of my communication skills with children was reliant on aspects of the hidden curriculum. The emergence of the hidden curriculum as an influential concept in medical education (6) means that subjects and skills which lie outside the more traditional framework of the formal curriculum are increasingly addressed in clinical education programmes. The American Board of Pediatrics has recommended that those working in paediatrics engage in specific training programmes in teaching and assessment of communication skills (7), and perhaps it's time we adopt similar programmes.

Communication challenges among those working in paediatrics posed by the COVID-19 pandemic and the ubiquitous wearing of face masks has been highlighted (8). As of yet, there remains little guidance in the anaesthesiology literature regarding how communication skills with children could be developed and improved upon, particularly in the context of anaesthesia provision at a time when the wearing of face masks in theatre and outside of it is commonplace. Communication skills do not need to be taught exclusively in the clinical setting, and setting aside time to deliver a workshop in communication skills with children could be transformative, for anaesthesiologist, parent and child alike.

END.

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References:

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Abstract:

Communication with children in the context of anaesthesia provision is a skill, the importance of which is especially highlighted by the COVID-19 pandemic and the ubiquitous wearing of face masks. Anaesthesiology consultants have been shown to display excellent communication skills that facilitate the development of rapid rapport and patient cooperation. Good communication results in positive interactions for hospitalised children, which correlates with improved health care outcomes. However, interactions with a child aren't always straightforward, particularly for trainees unfamiliar with certain communication techniques, which are important to utilise at a time when when the wearing of facemarks is commonplace.

Main text:

Communication skills with children in the context of anaesthesia provision is a skill, particularly when it comes to induction of anaesthesia. For the uninitiated - namely, anaesthesiology trainees entering into a paediatric anaesthesia rotation - peri-operative interactions with a child might not be straightforward, and plans for a smooth anaesthetic induction can be quickly upended. One might shrug and say "you win some, you lose some" but positive interactions with a child when they visit the hospital are important.

Good communication skills correlate with improved health care outcomes (1, 2). Conversely, poor communication can have the opposite effect, and result in a difficult, prolonged induction, distress and postoperative behaviour disturbances (3). Anaesthesiologists have been shown to display excellent communication skills that facilitate the development of rapid rapport, cooperation and trust with the patient, especially so in the setting of induction of anaesthesia in children (4). It is thus worth considering how such communication skills can be developed.

Induction is the transition from the awake to the anaesthetised state, and can be gaseous (involving the child breathing the anaesthetic agent through a mask) or intravenous (if the placement of a cannula can be negotiated). Unlike the usual doctor-patient dynamic encountered in theatre, this particular interaction typically comprises three members: anaesthesiologist, child and parent. For some, this can lead to a heightened degree of communication difficulty. Discerning non-verbal cues, managing child-parent dynamics, addressing the child's concerns, diffusing parental angst - all while planning, negotiating and delivering an anaesthetic. It takes perception and skill to utilise suitable, subtle techniques that facilitates a smooth induction.

Mis-firing chit-chat can lead to a protracted and stressful induction for anaesthesiologist, child and parent. The distress that often accompanies induction can be reduced, however, through good communication (5). Anaesthesiologists usually learn their communication skills through modelling of peers, and then develop these skills over decades of clinical interactions with children and their parents (2). This too was my experience - pay close attention to what the consultants do, and follow their example. I've certainly gotten better over time. Indeed, most health professionals feel that experience rather than academic coursework has taught them the necessary skills and techniques for communicating with children (6). However, the American Board of Pediatrics has recommended that those working in paediatrics engage in specific training programmes in teaching and assessment of communication skills and techniques (7), and perhaps it's time we adopt similar programmes.

The ubiquitous wearing of face masks during the COVID-19 pandemic has resulted in communication challenges among those working in paediatrics, with mask-wearing contributing to increased fear and poorer engagement among children in the hospital setting (8). In this context, enhancing communication skills among those working with children is key. Experienced anaesthesiologists do not rely exclusively on facial expressions to develop a rapport with a child, and the array of communication techniques they employ to negotiate induction can go unnoticed to the untrained eye. Skilled, dynamic use of story-telling, distraction techniques, vivid imagery and other hypo-therapeutic techniques are often used, and these can be taught to and employed by the less-experienced anaesthesiology trainees to enhance patient engagement and alleviate fear in theatre.

The array of communication techniques available to successfully negotiate an anaesthetic induction in children do not need to take years to perfect, nor do they need to be taught exclusively in the clinical setting. The emergence of the hidden curriculum as an influential concept in medical education (9) means that subjects and skills which lie outside the more traditional framework of the formal curriculum are increasingly addressed in clinical education programmes. Setting aside time to deliver a workshop in communication skills with children could be transformative, for anaesthesiologist, parent and child alike, particularly at a time when the wearing of face masks in theatre and outside of it is likely to be in place for the foreseeable future.

END.

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