

General practitioners' accounts of how to facilitate consultations with toddlers – an interview study

Marie Golsäter^{a,b}, Lars-Olof Johansson^a and Maria Harder^c

^aFuturum Academy for Health and Care Region Jönköping County, Jönköping, Sweden; ^bCHILD Research Group, School of Health Sciences, Jönköping University, Jönköping, Sweden; ^cSchool of Health Care and Social Welfare, Mälardalen University, Västerås, Sweden

ABSTRACT

Objective: To describe general practitioners' (GPs') accounts of how to facilitate consultations with children aged 1–2 years.

Design: A qualitative study based on focus group interviews.

Setting and subjects: Five focus group interviews were conducted with a total of 25 GPs at Swedish primary health care (PHC) centres. The GPs regularly invited toddlers to consultations.

Result: The GPs' accounts of how to facilitate consultations with toddlers revealed descriptions of making efforts to *instil confidence in the situation to enable the consultation*. Toddlers in need of health care always visit the GP with adults such as their parents, guardians or other relatives. Therefore, the GP directs efforts towards the adults and the child more or less simultaneously, as they both need to rely on the GP. The GPs describe how they instil confidence in the adults by *establishing a mutual understanding* that the consultation is necessary to secure the child's health. Regarding the child, the GP instils confidence by *establishing a relationship* in order to approach the child and accomplish bodily examinations.

Conclusion: The result shows that GPs' encounters with children in consultations are two-sided. The GP needs to conduct bodily examinations to secure the child's health and development, but to do so he/she needs to establish purposeful relationships with the adults and the child by instilling confidence. This indicates that establishing relationships in the consultation is significant, and a way to achieve a child-centred consultation.

KEY POINTS

Research regarding GPs' encounters with toddlers in consultation is limited, even though toddlers frequently visit PHC.

- GPs make efforts to instil confidence by establishing mutual understanding with parents and a relationship with the child.
- Establishing purposeful relationships with both the child and parent is significant in enabling the consultation.
- Establishing a relationship with the child overrides conducting the bodily examination, to promote the child's feeling of ease and allow a child-centred consultation.

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Introduction

Consultations involving children and their parents are common in general practitioners' (GPs') work, as children frequently visit primary health care (PHC) [1,2]. The assignment for GPs in Swedish PHC includes consultations to examine children's health and development. GPs evaluate healthy children's cognitive, motoric and social competencies and wellbeing, as well as examining sick children to restore their health. The GP's assignment is regulated by the health and

medical services act [3], and is also described in children's and adolescences' health and care [4]. Earlier research [5] speaks of GPs' need for family-focused consultations, understood as involving the parents in the child's consultation. The GPs describe consultations with children as triadic, or as balancing between two dyads, as their focus may move between the triad of GP–parent–child and the dyad of GP–child or GP–parent [6]. The available literature reviews focus on triadic encounters in consultations, and show that it is

CONTACT Marie Golsäter  marie.golsater@rjl.se  Futurum Academy for Health and Care, Region Jönköping County, Ryhov Hospital, S – 551 85 Jönköping, Sweden

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Table 1. Overview of the participants.

	Focus group 1	Focus group 2	Focus group 3	Focus group 4	Focus group 5
Number of participants	6	5	3	5	6
Sex m/f	2/4	2/3	1/2	1/4	4/2
GP/in training	5/1	0/5	3/0	5/0	6/0
Professional experience as GP/in training	9–26 years/5 years	1–5 years	3–5 years	4–30 years	3–30 years

preferably the GP and the parent who communicate [7,8]. Accordingly, even if there are three people – a triad – in a consultation, the child seems to be excluded. A suggested approach is child-centred consultations, in which the GP's reflected actions are directed toward the child and the parents or guardians simultaneously. Howell and Lopez [9] state that doctors, regardless of a child's age, need to reflect on what they want to achieve in a consultation with a child and what skills to use. The agenda in a consultation is known to the GP, but is not necessarily understood by the child due to cognitive development. The agenda may also be unknown to the parents due to lack of experiences of consultations. This can contribute to an intensified asymmetry in the consultation [10]. The focus in previous studies has been on communication and participation, rather than specifically on how to facilitate consultations with children. Also, these studies have involved children in the ages of 6–14 years; to the best of our knowledge, research regarding GPs' accounts of how to facilitate consultations with children aged 1–2 years is limited. Children in this age group, toddlers, preferably use their body to encounter others and rely on their parents to a great extent. This implies that the GPs need to be attentive to both the child and the accompanying adult in the consultation in order to enable bodily examinations and promote the child's health and development. The aim of the present study is to describe GPs' accounts of how to facilitate consultations with children aged 1–2 years.

Material and methods

In the present study, a qualitative inductive approach with focus group interviews was used in order to investigate the GPs' accounts [11].

Participants and setting

Five focus group interviews were conducted at Swedish PHC centres, with 25 GPs who regularly met toddlers in consultations. To get a variation of accounts, GPs from four different PHC centres representing rural as well as urban areas were interviewed.

Each of these PHC centres is responsible for about 9000–12,000 patients, 800–1100 of whom are children aged 0–6 years. After permission was received from the managers at each PHC centre, the participants were contacted by one of the investigators. GPs with extensive experience and doctors in training participated, including both male and female GPs. An overview of the participants is presented in Table 1.

Data collection

The audiotaped focus group interviews took place at four different PHC centres. One of the investigators (LJ) moderated all the interviews based on a semi-structured, open-ended topic list covering the different parts of the consultation [12]. Each focus group interview started with the question "Tell me how you encounter children aged one to two years in consultations?" In the interviews, the main focus was on facilitating factors in the encounter. Follow-up questions were used to support the discussion i.e., "Tell me more" or "Explain further how you act" to clarify and deepen the discussion. At the end of each interview, the second investigator present (MG) summarized the discussion to allow the participants to reflect on and further clarify and confirm their discussion [12]. The moderator has long experience of working as a GP, which helped in conducting and following the discussions in the focus group interviews. The second investigator present paediatric nurse, with former experience of conducting focus groups interviews within health care, which enabled her to ask clarifying questions during the summaries. The interviews lasted about one hour, and were audio-taped and transcribed.

Data analysis

The interview data were subjected to the principal of inductive content analysis by Elo and Kyngäs [13]. The analysis, comprising the three main phases of preparation, organizing and reporting, was performed in different steps. First, the transcripts were read several times by the three investigators to obtain an overview of its content and capture essential features. In the next step, the transcripts were coded based on the

Table 2. Overview of subcategories, generic categories and main category emerging from the analysis.

Subcategories	Generic categories	Main category
Acting reliably	Establishing mutual understanding with the parents	Instilling confidence in the situation to enable the consultation
Reaching an agreement		
Providing the child with space	Establishing a relationship with the child	
Paying attention to the child's states of being		
Inviting the child into the consultation (<i>initiating, conducting and concluding the medical examination</i>)		

descriptions of the GPs' accounts. In the third step the codes were compared based on similarities and differences, and in the fourth step the codes were grouped into preliminary categories. In the remaining three steps, two of the authors (MG, MH) first identified the subcategories and the links between them, and then abstracted the subcategories into the two generic categories. Finally, the generic categories were abstracted into the main category: instilling confidence in the situation to enable the consultation see [Table 2](#).

Ethical consideration

According to Swedish law [14], the approval of an official research ethics committee is not required for research involving health care professionals. The study was performed in accordance with the guidelines issued by the World Medical Association [15]. The managers of the PHC centres gave permission to conduct the study. The participants received written and oral information about the study, including that they had the right to withdraw from the study at any time and that the data would be treated confidentially in accordance with the Swedish Personal Data Act [16].

Results

GPs' accounts of how to facilitate encounters with toddlers are understood as their efforts to *instil confidence in the situation to enable the consultation*. Toddlers in need of health care always visit with their parents, guardians or other relatives i.e., an adult; in this study, the concept *parent* is used as this is the term the GPs used in the interviews. The GPs describe how they direct their efforts towards the parents and the child more or less simultaneously, as both the parents and child need to rely on them. The GPs instil confidence in the parents by *establishing a mutual understanding* that the consultation is necessary to promote the child's health. Regarding the children, the GPs instil confidence by *establishing a relationship* in order to approach the child and accomplish the consultation.

Establishing mutual understanding with the parents

The GPs describe how they establish a mutual understanding between themselves and the parent through a process starting with their *acting reliably*, and proceeding to *reaching an agreement* with the parent to conduct the necessary examinations on the child. The GPs state that when a mutual understanding is established with the parents, the consultation proceeds smoothly. Further, the GPs describe that the parents are able to ease the situation by making the child feel secure. The mutual understanding between GP and parent is accounted for as something that enables the encounter with the child and establishes a relationship.

Acting reliably in the consultation is described by the GPs as establishing contact with the parent before doing so with the child. According to the GPs, this entails talking to and establishing eye contact with the parent. Establishing contact with the parent is cited as especially necessary when the child is anxious. The GPs describe that acting reliably also means informing the parent straightforwardly and honestly. They also describe how they affirm the parent in his/her parenthood by praising the child, listening to the parent's own assessments of the child's situation, and explaining the child's health and development to the parent.

I talk with the parent first if they have any special concerns for the visit, let the child get the sense that I'm there, the parent has to approve me first (Focus group (FG) 3).

The GPs state that when they act reliably the consultation proceeds towards *reaching an agreement* with the parent. They describe that agreement is reached by talking about necessary examinations and getting the parent's approval to carry them out. According to the GPs, reaching an agreement with the parent also involves how to perform the examination if the child refuses to cooperate.

Involve the parents in the consultation so that it's not the doctor against the family, so you cooperate with the parents regarding the child and get them on board: Mummy and I know this will be okay (FG2)

Establishing a relationship with the child

The GPs describe how a relationship with the child is established through a process initiated by the GP includes *providing the child with space*, and proceeds with the GP *paying attention to the child's states of being* and *inviting the child to the consultation*. They state that this process enables them to adjust to the child and decide how to conduct the different parts of the consultation. The GPs describe that how a relationship is established depends on what a certain GP is comfortable with. If they do not feel comfortable in the situation, e.g. sitting on the floor and playing, this will not facilitate in establishing a relationship. The GPs explain that each GP needs to find his/her own way of acting. Further, they state that establishing a relationship with the child is superior to conducting bodily examinations. The GPs describe that promoting salutary experiences and the child's feeling of ease is of importance. They state that succeeding in establishing a relationship with the child makes it possible to conduct the examinations.

Providing the child with space in the consultation involves GPs' accounts of how and when they make contact with the child. The GPs describe how, at the beginning of the consultation, they can ignore the child in order to not appear threatening and to allow the child to get used to the situation. Further, the GPs explain how they observe the child from a distance, act slowly and try to minimize themselves bodily by, e.g. bending down and asking the parent to put the child on the examination table. If the first attempt to make contact with the child fails, the GP takes a step back and tries again later.

I greet the child first, whether it's here or at the child health care centre, and then I ignore them a bit and talk to the parent and let them take in the surroundings as well as watch me from a bit of a distance; I always keep myself at somewhat of a distance, then I always approach the child by playing with them a little (FG1).

The GPs describe how they *pay attention to the child's states of being* by observing the child's body language and preparedness. According to the GPs, such observations enable them to encounter each child with respect to his/her development and experiences, general condition and illness. Further, they tell how these observations allow them to sense the right moment to invite the child into the different parts of the consultation.

You have to fairly quickly get a sense of which mode the child is in, because you only have one chance and have to be very cautious from the outset, and you

have to feel it in a way. In the beginning it was a lot harder than it is now (FG2)

According to the GPs, paying attention to the child's state of being enables them to prioritize the order of the different parts of the consultation. During an ongoing consultation paying attention to the child's state of being – e.g. crying or protesting – helps the GP renew his/her priorities regarding the examinations that are needed, or to act quickly to carry them out.

You have to assess what's most important... You don't have to get into everything; if one ear hurts you don't struggle with the child to see both eardrums (FG4)

The GP's consultation with a child includes *initiating*, *conducting* and *concluding medical examinations*. Initiating the medical examination involves the GP's attempts to come physically close to the child and begin an interaction by sitting down beside the child through acting, playing and talking. According to the GPs in this study, they try to find something they have in common with the child, e.g. showing interest in what the child is playing with. They also describe how they make an effort to awake the child's interest and curiosity in order to bring the child into the examination. This is done by talking about the examination and letting the child familiarize itself with the examination tools by touching and holding them. The GPs explain that when they conduct the medical examination, they talk about what they are doing in order to hold the child's attention.

I have a trick, it's such a ridiculous thing but when I listen to the heart, especially if the child is 11/2 and approaching 2, I have a small game: "Now we're going to listen to your heart (whispering). Very quiet, I'll listen ..." and so I listen silently, it's like a little game, and they usually sit like this (shows a somewhat surprised, expectant expression) like a game, "Do you hear something"? (FG1)

The GPs explain that, when both conducting and concluding the examination, they can direct the child's attention from the examination using toys, pictures or examination tools, or looking out the window at cars. This way of directing the child's attention away from the examination enables the GPs to conduct the examinations needed. But it is also intended as a way to make the child feel secure in order to promote salutary experiences, according to the GPs.

Putting the child in front of an activity board, so they can focus on it, then you can sneak the stethoscope in and do the examination they don't like. (FG4)

Discussion

Principal findings

This qualitative interview study from Swedish PHC shows that GPs' encounters with children in consultations are two-sided. The GPs describe a need to conduct examinations with children to secure their health and development, but in order to do so they must establish purposeful relationships with parent and child by instilling confidence. This indicates that establishing relationships in the consultation is significant, and a way to achieve child-centred consultations.

Findings in relation to other studies

The present study shows how the GPs encounter children by instilling confidence through establishing a mutual understanding with the parent and a relationship with the child. Consultations in PHC are situations in which a relationship is established between GP and patient, regardless of whether the patient is an adult or a child [17–22]. Further, the present study shows that the GPs' encounters entail instilling confidence. Confidence gives satisfaction and a feeling of ease for both child and parent [22], which enables the GPs to conduct the consultation in an agreeable way. That the GPs established a mutual understanding with parents by acting reliably and reaching an agreement is also confirmed [22]. They generally describe it as achieving consensus, entailing reassurance that the patient accepts their explanation.

When the patient is a toddler, as in the present study, the encounter is a process that involves establishing relationships with both parent and child. The GPs involved in the present study told how they established a mutual understanding with the parent by acting reliably, e.g. making the first contact with the parent and affirming the parent in his/her parenthood. Ertman [18] and Sharma [23] state that parents visiting PHC with their child may have difficulties assessing the child's state of development or illness. They feel insecure about doing the right thing, and at the same time are anxious about their child. This does not indicate that the parents lack knowledge [18], but rather that they need reassurance, guidance [22,23], and to be listened to [6,22]. Jeyendra [20] describes that GPs working with families identify their role as one of an educator and a provider of support. Therefore, to enable a GP–child relationship, establishing mutual understanding with the parent is of significance.

By acting reliably, the GPs in the present study were able to reach an agreement with the parent to

examine the child. This is consistent with Taylor et al. [24] who describe that using a collaborative approach is needed in order to diagnose a child's health problems. Also, Howell and Lopez [9] suggest that GPs need to make children and their parents feel comfortable early in the consultation, to enable them to conduct it without distress. Ertmann [18] states that when agreement is not reached even though the GP has acted reliably and explained the child's illness the parents may become defensive. Such a relationship between the GP and the parents will jeopardize the GP's possibility to establish a relationship with the child.

Accordingly, a purposeful relationship is significant with both children and their parents in the consultation. This corresponds with Crossley and Davies [22], who suggest that doctors in consultations with children need to address both the child and the parent. Also, Lykke [6] describes how GPs work from "reflection-in-action" when they need to address an issue in the consultation and how they choose to deal with it. Despite how the GP decides to deal with a raised issue, the strategy used always entails an attempt to establish a relationship with the family, to build trust and confidence [5,6]. The GPs' effort to maintain the relationship with a family affect their actions for example when facing suspected child abuse [25] and when deciding to prescribe antibiotic or not to a child [26]. The significance of relationship is further confirmed by parents, who state that an established relationship contributes to their continuous involvement in the consultation regarding their child [24].

The present study focuses on GPs' consultations with toddlers, and the result shows the GPs' establishment of a relationship with the child. Despite the focus on encounters with children, the result shows that the GP puts effort into establishing mutual understanding with the parent before encountering the child. This means that the parent's confidence in the GP is understood to be the key to success in the consultation. It is further understood that toddlers may need to feel that their parent is confident in the consultation. However, specific actions toward the parent can be understood as other actions toward the child. A GP turned toward the parent to instil confidence by acting reliably implies that the GP, simultaneously, provides the child with space by, e.g. ignoring the child and letting him/her get used to the situation. This could be described as parent-centredness and child-centredness [22] occurring at the same time.

Child-centred consultations do not exclude the parents, as they – according to the result in the

present study – are the key to the GP's ability to perform the examinations in a suitable way. Therefore, the parent is included in a self-evident way. A child-centred consultation automatically includes the parent, it also emphasizes paying attention to the child's state of being, and reflecting on the performance of the consultation. The GPs in the present study pay attention to the child's state of being by observing their body language. Such observations allow them to adjust their own actions and their decisions regarding the examinations needed in the prevailing circumstances. This corresponds to previous research showing that in a consultation the GP has to interpret the patient's needs [21], that consultations include being sensitive to the child's non-verbal cues [22], and that observing the child's appearance and behaviour enables the GP to adapt the procedures that are needed [6].

The GP's actions of providing the child with space and paying attention to its state of being override performing the medical examinations needed to secure the child's health and development. This is consistent with previous research stating that the child should not be rushed in the consultation but rather helped to feel at ease [24]. The examinations involve the GP, as an unknown person, needing to come physically close to the child in order to examine, e.g. its ears, eyes, stomach, heart and lungs. Howell and Lopez [9] state that toddlers may be difficult to encounter for bodily examinations, as they can be shy and suspicious of people they do not know [9]. The result in the present study also shows that the GPs emphasize the importance of their continuous communication of what they are doing in order to hold the child's attention. This can reassure the child that everything is all right, and may reduce anxiety for both the child and the parent [9]. Nova et al. [27] claim that consultations provide an opportunity for the child to learn to be a patient, and an introduction to the relational aspects of the consultation as well as the child's own role in the situation. To reach such knowledge, child-centred consultations are needed. It is necessary to incorporate a specific focus on the child him/herself, but not at the expense of the parents.

Strengths and weaknesses

The focus group interviews incorporated GPs with a variety of professional knowledge in order to achieve a rich description of experiences of encountering toddlers. Throughout the interviews the participants revealed different ways of encountering children, sharing and discussing what strategies were most helpful. This argues for the focus group interviews as a

trustworthy method for data collection in this study. A limitation in the sample is that all participants were recruited from the same county. However, the participants had had their medical training at different universities in Sweden, which is understood as an advantage in achieving rich descriptions. The participants in the focus groups knew each other, through working in the same PHC area, which could have influenced the discussion both positively and negatively. However, through the interviews the participants showed great interest in each other's accounts and there was an open discussion in which all participants were active, which indicates that the chosen data collection method was appropriate.

All authors participating in the analysis held different occupations (GP, paediatric nurse and public health nurse) and different experiences of encountering children in health care. Their different experiences enabled a wide analytic space, and through purposeful discussion throughout the analysis trustworthiness was supported [11].

Conclusions and implications for clinicians

The main finding shows that a GP's skills in encountering various children and parents are a prerequisite for conducting consultations. Implications for clinicians include the need to start by establishing a relationship with the parents, and not to be overly keen on the child but instead provide him/her with space to get used to the situation. Further, GPs need to be aware of the child's state of being and show interest in the child in order to be able to recognize when he/she is ready to take part in the consultation, and support the child throughout the consultation by playing and talking. Synthesizing the need to establish purposeful relationships with the need to perform the necessary examinations requires training, shared reflections, and an ability to recognize which of one's own actions are suitable in a specific consultation. A link between what one says and what one does may not always be evident; therefore further research, based on video recordings of the consultation, may be one way to deepen the knowledge of GPs' consultations with toddlers. Another way to help GPs elaborate on their consultations with toddlers could be to provide parents with a rating scale regarding the GPs' encountering their children [28].

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