Original Article

Ten Years Analysis of Parental Counselling-in-Continuum in Paediatric Surgery: Psychosocial and Medico-legal Outcome

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Abstract

Background: Parents are anxious and apprehensive about the health of their children. A standardised, reproducible and meticulous parental counselling is helpful to both the parents and the treating doctors, as well as markedly reduces instances of scrimmage and medico-legal litigations. The aim of this study is to assess the psychosocial and medico-legal outcomes of parental counselling-in-continuum (PCiC) in paediatric surgery. **Materials and Methods:** The study was conducted at two government-run Tertiary Healthcare Centres in North India. The study design involves prospective feedback-based study. It included all the admitted paediatric surgery patients. Periodic multisession PCiC was done for each patient by three paediatric surgery teams from 2011 to 2021. At the time of discharge, feedback was taken to assess the psychosocial outcome of PCiC, and the medico-legal outcome was calculated based on the number of litigations. **Results:** A total of 22,353 admissions were done in paediatric wards at these institutes. 1574 cases were managed conservatively and 20,779 patients who underwent surgeries were included in the study. 4758 (22.89%) were emergency procedures and 16,021 (77.11%) were elective procedures. Parents rated the counselling efforts excellent in 18,285 (81.80%), good in 3162 (14.14%), satisfactory in 876 (3.91%) and poor in 30 (0.13%) cases with zero medico-legal litigations and 12 incidents of scrimmage. **Conclusions:** PCiC, being a novel concept, should form a centerpiece of paediatric surgical management as it maximally enhances the patient satisfaction level and protects the treating paediatric surgical team from scrimmage and medico-legal litigations.

Keywords: Counselling, medico-legal, parental counselling-in-continuum, paediatric surgery, psychosocial

Introduction

The 21st century is the era of technology, knowledge and information is available at every fingertip. Today, patients and their attendants are no longer completely dependent on medical experts to provide them with health information. There is an increased availability of information and patients have become more and more aware of disease conditions as well as their legal rights which have changed the approach to medical practice. Medical information being a 'double-edged sword', on the one hand, helps provide better health care while increasing confusion on the other if it is half-baked, incorrect or wrongly perceived.

Children are our future, and we should take care of them with maximum effort. Parents, being extremely anxious and apprehensive about the health of their children, are more curious about disease conditions and therapeutic procedures being performed on their children. Most childhood surgical diagnoses, congenital or otherwise, come as a shock to parents who are unaware of these diseases (despite some being antenatally diagnosed). In contrast, medical and surgical issues in adults are relatively common in occurrence and known to or at least heard by most of the population. At the same time, the parents and elderly in the family may react unpredictably to any morbidity, complications and mortality of their sick child. Therefore, counselling, use of soft skills management and style of communication with the parents and relatives need to undergo a facelift which would not only ensure better

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clientele satisfaction, minimise the risk of aggression and physical violence by the attendants but also decrease the legal litigations and complications.

World Health Organization defines counselling as a well-focused process that uses interaction to help people deal with difficulties and respond properly to a specific situation to develop new coping strategies.[1] Parental counselling-in-continuum (PCiC) is a unique, conscientious and empathetic way of parental counselling, which is an ongoing, dynamic process done in multiple sessions in synchrony with the progress or deterioration of the child. Parents are counselled at the first visit to the hospital (as an outpatient or in the casualty department), then preoperatively and on multiple occasions during the course of the hospitalisation of the child. After surgery, the head of the surgical team should take out time for counselling the parents about the findings of the surgery and the course thereafter to keep them abreast with the clinical status. The use of audio-visual (AV) aids is preferred on a case-to-case basis as and when deemed necessary.

In India, over 23 million babies are born every year. Among these, 2% of babies are born with a congenital defect, and 0.01% of these require an urgent surgical intervention to survive. This represents a huge paediatric surgical load in India. The facility of paediatric surgery is available at some Government Tertiary Healthcare Centres and a few private centres. Thus, there is a deluge of patients versus few paediatric surgeons to deal with paediatric surgical cases.[2] This necessitates the adoption of a standardised, reproducible and meticulous parental counselling along the lines of PCiC, which is helpful to both the parents and the treating doctors as well as markedly reduces instances of medico-legal litigations, and also tends to decrease cases of hospital vandalism and doctor battering as the majority of these cases do not depend on clinical care but the quality of communication and behaviour of team providing health care.[3]

PCiC is a novel concept in paediatric management. We aim to shed light on this concept and its positive effects on patient satisfaction levels, thus building stronger trust and faith between the treating doctors and the parents. The primary aim of our study is to showcase the positive outcomes of the use of PCiC in improving clientele satisfaction and secondarily to reduce the legal litigations and incidents of scrimmage against the treating doctors and nurses.

Materials and Methods

This prospective study was conducted on all the paediatric surgery patients who were admitted to two government-run Tertiary Health Care Institutes and managed by three paediatric surgery teams from 2011 to 2021. The study included patients undergoing surgery as well as those who were managed conservatively. Written consent for the study was obtained from each participant. Each paediatric surgery team primarily included 22–26 health-care workers (consisting of 2 paediatric surgeons, 2 neonatologists, 2 paediatricians, one paediatric anaesthethetist, 4 senior residents and 2 junior residents on a rotation basis) [Figure 1]. A counsellor trained in family, child, and grief counselling was also involved on a case-to-case basis. At the first outpatient department (OPD) visit, parents were issued a bilingual, information booklet that contained answers to frequently asked questions about common surgical ailments in the paediatric age group.

Parents and relatives of all patients, who were admitted, operated or managed conservatively, were counselled on multiple occasions through PCiC using a predesigned counselling form, apart from routine preoperative consents. This self-explanatory form [Figure 2] focuses on the patient's details, clinical findings, a pictorial description of the clinical issue, treatment options available use of AV aids on a case-to-case basis, and possible complications (expected and unexpected), followed by provision for doubts and queries by the parents. Most importantly, these queries and apprehensions are cleared in the simplest manner possible in each PCiC session. We have devised an efficient grievance addressal system, in which suggestion boxes are placed in the OPD and complaint resisters are placed in the wards, which are checked daily by the resident-in-charge. The complaints and grievances were noted and acted on timely.

This form was duly signed by parents, relatives and the counselling doctor at each point of time when counselling sessions were conducted. The counselling team comprised a paediatric surgeon, a paediatrician, a paediatric anaesthetist, senior as well as junior residents, and a counsellor wherever deemed necessary. Written feedback was taken using a pre-designed questionnaire at the time of discharge to assess the psychosocial outcome in the form of their thoughts about PCiC and satisfaction level regarding the management of their child's treatment [Table 1]. Based on the total score, patients were distributed among four categories such as poor (score – 8 or less), satisfactory (score – 9–12), good (score – 13–16) and excellent (score – more than 16). The duly filled forms of consent, PCiC, and feedback were kept with the medical record department of the respective hospital for future reference. Written consent for participation in the study was taken from the parent/guardian of each patient.

Results

In our study, 134,684 patients visited the OPD and casualty at two tertiary health-care centres. A total of 22,353 admissions were done in paediatric wards at these institutes including 17448 patients through the OPD and 4905 through casualty. One thousand five hundred and seventy-four cases (such as blunt trauma abdomen, non-specific pain abdomen, foreign-body (FB) ingestion, etc.) were managed conservatively and 20,779 patients who underwent surgeries were included in the study. As the feedback form was filled out each time the patient was discharged, the sample size consisted of 22,353 cases. The average monthly paediatric surgeon-to-patient ratio for admitted patients was approximately 1:31. Out of the total admitted patients, 3729 (24%) were neonates, 8229 (28%) were infants and

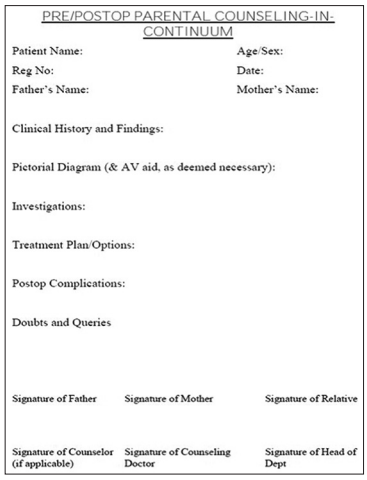


Figure 1: Scheme of study

the rest 10395 (48%) were between the ages of 1 year and 12 years [Figure 3].

In total surgeries performed, 4758 (22.89%) were emergency procedures and 16,021 (77.11%) were elective procedures. Eleven thousand nine hundred and forty-one (57.47%) patients underwent various open procedures and 8838 (42.53%) patients were operated using minimally invasive procedures (such as laparoscopy, video-assisted thoracoscopy and cystoscopy). Nine thousand five hundred and ninety-six (46.18%) genitourinary anomalies, 6899 (33.2%) gastrointestinal anomalies, 1473 (7.09%) developmental defects, 746 (3.59%) for neoplasms and 2065 (9.93%) miscellaneous such as trauma, head-and-neck cysts, pleural effusion, etc., were surgically addressed [Figure 4].

As far as surgical outcome is concerned, both minor and major complications were recorded and analysed. There were 352 (1.69%) minor complications such as surgical site infection, wound dehiscence, FB granuloma, post-operative sepsis and urinary tract infection, whereas 77 (0.37%) major complications such as reactionary haemorrhage, redo surgery for failed primary, anastomotic leak requiring re-exploration of the abdomen or chest, or a redo ventriculoperitoneal shunt surgery. Overall mortality was 189 (0.84%). These subsets of cases with complications and mortality were specifically catered for with the practice of PCiC. The total number of recorded incidents of scrimmage was 12 (0.05%), which were immediately resolved amicably due to our protocol-based feedback mechanism and timely intervention. The available team member on duty cleared the misunderstanding that the distant relatives had, as they were never a part of the initial PCiC and seemed unaware of the expected postop complications. Most importantly, there was no incident of medico-legal litigation in a total of 10 years on any member of the team or the hospital itself.



PRE/POSTOP PARENTAL COUNSELING-IN-CONTINUUM

Patient Name: Age/Sex:
Reg No: Date:
Father's Name: Mother's Name:

Clinical History and Findings:

Pictorial Diagram (& AV aid, as deemed necessary):

Investigations:

Treatment Plan/Options:

Postop Complications:

Doubts and Queries

Signature of Father | Signature of Mother | Signature of Relative

Signature of Counselor (if applicable) | Signature of Counseling Doctor | Signature of Head of Dept

Figure 2: Parental Counselling-in-Continuum Form

Table 1: The PCiC feedback form

Counselling-in-continuum feedback form		
Patient name		Age/sex
Father's name		Mother's name
Diagnosis		Doctor's name
Serial number	**Question**	**Scoring**
1	How did you perceive counselling provided to you by the surgical team?	Excellent - 3 Good - 2 Waste of time - 1
2	Was the surgical team approachable to you?	All the time - 3 Occasionally - 2 Never - 1
3	What do you think of repeated counselling sessions provided in terms of benefits to you?	It was informative and transparent - 3 It was informative but lacked clarity - 2 Unnecessary - 1
4	Was the surgical team capable of making you understand the nature of the disease and the treatment plan for your child?	Yes, we understood both - 3 Yes, but still confusion was not completely cleared - 2 No - 1
5	Did counselling help you in coping with the stress of illness/procedures?	Yes, the stress was completely alleviated - 3 Yes, but the stress was not completely relieved - 2 No - 1
6	Was the counselling doctor empathetic?	Yes - 2 No - 1
7	Did the surgical team give ample time to you during counselling?	Yes - 2 No - 1
8	Did you find the disparity between counselling sessions provided by different doctors?	No - 2 Yes - 1

Maximum score - 21, Minimum score - 8

We found that 96% of parents of our patients found this PCiC extremely helpful and gratifying as they rated these counselling efforts excellent in 18,285 (81.80%), good in

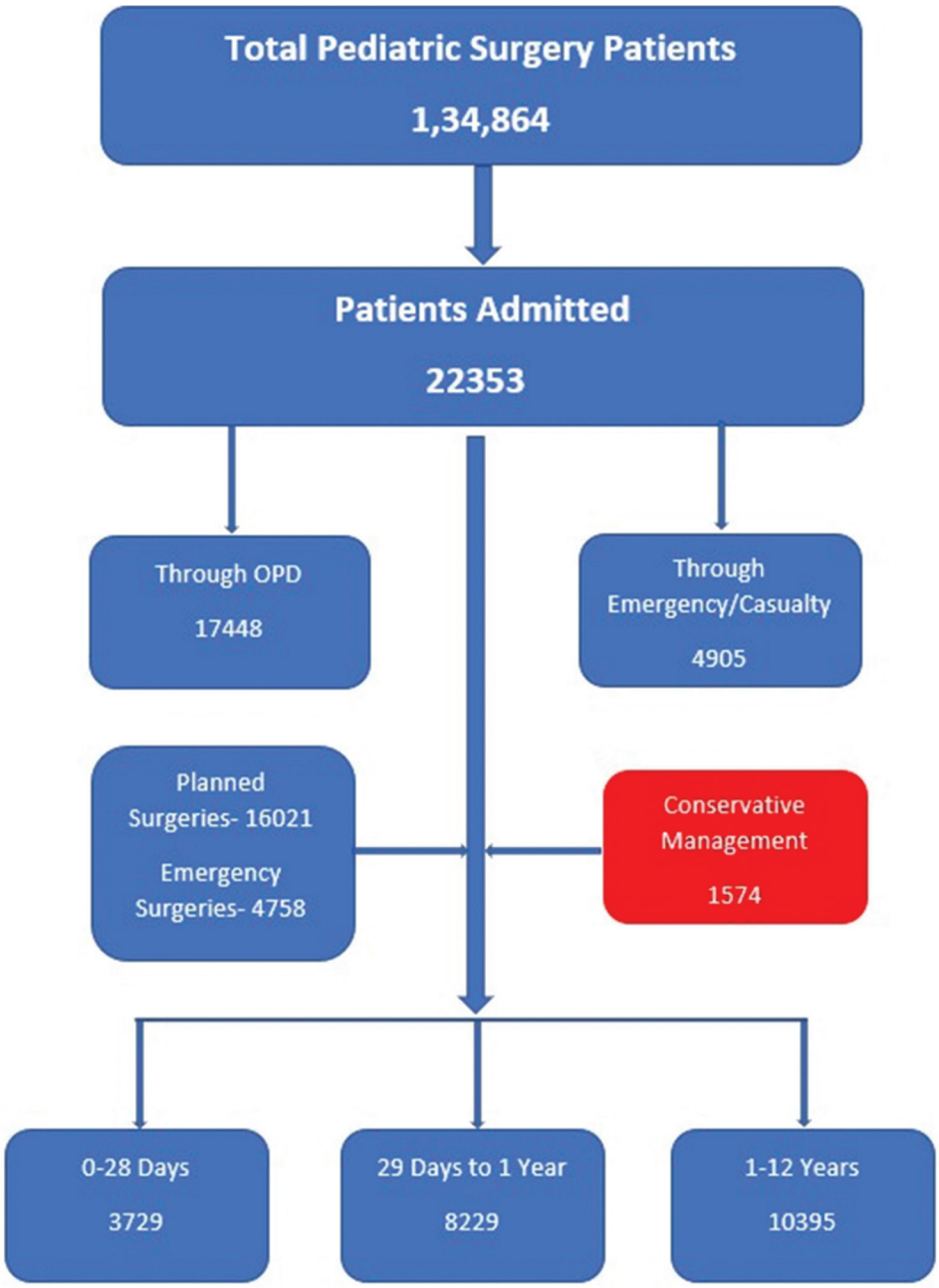


Figure 3: Distribution of Paediatric Surgery patients. OPD: Outpatient department

3162 (14.14%), satisfactory in 876 (3.91%) and poor in 30 (0.13%) cases [Figure 5]. The amount of time spent per session of PCiC per patient ranged from 5 to 20 min. The first session always needs a little more time, after which the repeated sessions are much shorter. Furthermore, with experience and practice, all the members of the team, including the junior staff, perfected the art of PCiC in an optimal amount of time.

Discussion

Our study included 22,353 admitted cases of paediatric surgery managed by 6 paediatric surgeons at two tertiary health-care centres over a period of 10 years, of which 20,779 patients underwent surgeries. The average monthly paediatric surgeon-to-patient ratios for patients attending OPD, admitted, and undergoing surgery in our study were approximately 1:187, 1:31 and 1:29, respectively. The authors are privy to the fact that globally there would be some centres with much higher doctor–patient ratio. This gives a glimpse of the tremendous surgical load a paediatric surgeon faces which necessitates the adoption of a time efficient, standardised PCiC to achieve maximal clientele satisfaction and minimise the legal litigations. A recent systematic review found that the median paediatric surgical workforce density for low-to-medium income countries is 0.12.[4]

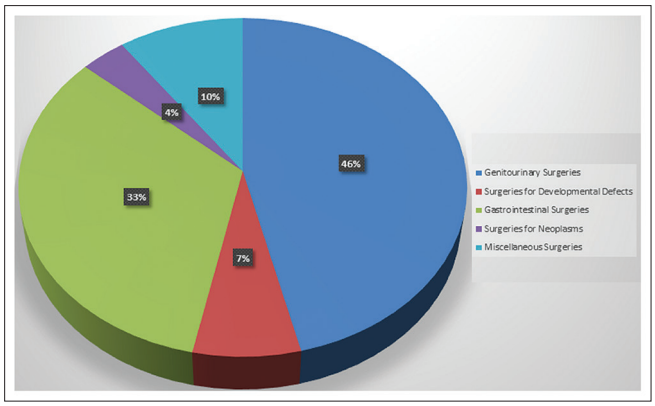


Figure 4: System-wise distribution of paediatric surgeries

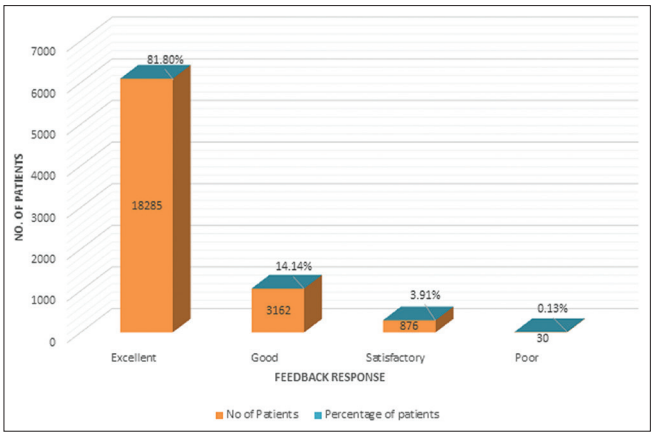


Figure 5: Feedback Response of PCiC. PCiC: Parental counselling-in-continuum

We observed that 57.47% of patients underwent open surgeries, whereas a study by Chong *et al*. found that patients are twice likely to undergo open procedures than minimally invasive ones.[5] We found that 46.18% of patients were operated on for genitourinary anomalies and 33.2% of patients for gastrointestinal ailments. The spectrum of paediatric surgeries in our study was partly similar to a Nigerian study by Ajao and Adeniran.[6] Overall mortality was seen in 189 cases.

The lack of soft skill training for doctors has furthered the scrimmage problem. Misleading mass media and political propaganda add fire to an already volatile situation.[7,8] Approximately, 75% of doctors have faced violence or aggression in some form or the other during their service.[9] According to a German study, there were 129 medico-legal litigations against paediatric surgeons over a period of 5 years. The risk of conviction for these litigations was found to be 2.27% per year for a paediatric surgeon.[10] Another study from the United States of America reported that 41% of total medico-legal cases were lodged against paediatric surgeons, making them most vulnerable to getting sued.[11]

Medico-legal litigations as well as events of scrimmage with hospital staff, also tend to be more in the case of paediatric patients as it is very difficult for parents to accept the adverse outcome. The apex court of our country has put the medical professional under constant and strict vigilance through the purview of the Consumer Protection Act of 1986. In 1999, the Supreme Court ruled that medical professionals are liable for negligence suits irrespective of payments towards their medical services, making counselling a cardinal element in health care. Thus, parents of every patient admitted to the hospital must be counselled, and no differentiation should be made on the basis of socio-economic status.[12]

We have devised a protocol and propose that the paediatric surgery team must modify its approach towards parental counselling by ensuring that parents and visiting relatives must be counselled thoroughly and at multiple points throughout the course of management of the paediatric patient on the lines of counselling-in-continuum. In cases where the parents lack cognition of the seriousness of the illness and/or seem to be ignorant due to lower educational level, a relative with a better understanding and educational qualification should be sought to take part in PCiC.

PCiC aims to provide the information in a way that it is easy for parents and relatives to understand the disease condition, give an idea about possible outcomes of the disease and help them to choose between various treatment modalities available in modern medical science with their pros and cons. Furthermore, the practice of PCiC is always intended to make the sessions transparent, wherein the parents go back satisfied that their queries, doubts and apprehensions were addressed. The parents, caregivers and any elders of the family must feel involved in the decision-making with respect to the surgical treatment of their child. Since paediatric surgical management of most of the critical cases involves multiple sub-specialities such as neonatology, paediatric anaesthesia, paediatric critical care, paediatric gastroenterology and radiology, the authors devised a protocol wherein the reps of these sub-specialities also were involved in counselling the parents on a case-to-case basis.

The results of our study demonstrate the vital role PCiC plays in having a satisfied parent and an excellent litigation-free outcome for the paediatric surgery team. Ninety-six percent of our clientele were extremely satisfied with the PCiC (81.80% excellent, 14.16% rated it as good), which suggests that if properly done, this method of counselling not only relieves anxiety, and lessens the fear but also helps in building trust and rapport with the treating team. This further translates into better compliance to advice and prescription, consequently in improved healing and survival of paediatric surgery cases. PCiC significantly reduced patient dissatisfaction as well as any resultant aggressive scrimmages from the parental side towards the treating team despite there being a substantial increase in surgical caseload. Apart from the PCiC, the availability of feedback mechanisms (suggestion boxes in ward and OPD complex) gives the parents an opportunity to vent out any grievances which were diligently looked into and resolved on priority. This rapid grievance redressal mechanism further aided in increased clientele satisfaction.

A high degree of parental satisfaction, excellent feedback in most of the cases as well as miniscule number of aggressive incidents by attendants and finally zero medico-legal litigations against any of the team members, displays the emphatic psychosocial outcome of PCiC. Quite a few paediatric surgery patients have to undergo multiple surgical corrective procedures for the same ailment, which entails repeated OPD visits, hospital admissions and multiple times anaesthesia, and it adversely affects the psychology of the child, parents and other family members. Thus, parental counselling, being a sensitive issue and a vital part of management, should preferably be done by a senior member of the treating team in selected cases where there is a risk of complications or revision procedures; this practice helps in building the bond of trust between parents and health-care providers. With the vast experience of senior members (senior doctors and matrons), we also kept an eye on the parent or relative who could react violently to an adverse outcome and we provided them with extra sessions of PCiC to ensure their understanding of the situation was at par with the doctors.

Responsibility of PCiC may be deputed to junior members under the supervision of senior most members and utmost care should be taken to provide accurate information. Thus, each member must master the delicate art of parental counselling as wrong information by a junior member may prove devastating to the counselling effort. A counsellor trained in family, child and grief counselling plays a vital role during the hospitalisation of the child. The surgical issues, multiple hospital visits, repeated admissions and surgeries can all have an adverse impact on the psychological state of the patient as well as his/her parents. When mortality occurs, the grief of the loss of a child to an abrupt onset illness is unparalleled and arduous to accept. It is reiterated that PCiC should not be a rigid process and be modified on a case-to-case basis.

We propose that PCiC should be a well-focussed process and should incorporate the following fundamental principles:

a. Accuracy: Information given to parents or relatives should be accurate as per current medical literature, as incorrect information can misguide the parents as well as can lead to breaching the trust between parents and physicians
b. Brevity: The counselling process should not be 'Beating around a bush'. It should be as concise and exact as possible. Long and unnecessary information adds confusion to an already troubled and anxious mind
c. Clarity: Counselling should not contain unnecessary medical jargon. It should preferably be in a language well understood by parents, the help of translators can be taken in the case of a language barrier. Pictorial diagrams and photos can be used in the counselling process for better understanding wherever deemed essential
d. Reproducibility: Counselling process should be such that it can be reproduced by every member of the team and should be standardised to the extent that it should not vary from person to person and centre to centre. This will make the widespread application of PCiC more feasible
e. Empathy: Empathy being the most important but underrated element of the counselling process, adds a human and emotional touch to the process. The doctor, as a counsellor, should think from the perspective of parents and relatives. Empathy strengthens the bond between both parties involved in the process.

Table 2: The "A to I" of Dos and Don'ts of PciC

Do's	Don'ts
Attitude - Humility and soft-spoken is a virtue which has the best outcome for any doctor	Attitude - Arrogant attitude for a doctor undoes all the good done. Must be avoided
Accessible - Any of the team member must always be available to parents	'Above all' image - Doctor should not impose an image of being in a superior position
Audio-visual aid - Wherever deemed necessary, help of audio-visual ai should be taken	
Brevity - Counselling should be done in concise but meaningful words	Blunt - Counselling should not be done bluntly. Soft skills must be adopted to break any news
Bereavement- In case of an adverse outcome bereavement committee must be actively involved	'Beating around bush' - Should be avoided
Cohesive - All members of treating team should be on the same frequency, difference of opinion amongst the team members invites trouble and can cause confusion	Curt - Counselling process should not be rudely cut short or sound abrupt without description
Clarity - PCiC should be done in clear words, in language well understood to parents, medical jargons should be avoided	Confused - The doctor must not look or explain in a confused manner to avoid confusing the parent
Downright simple - Keep it simple, in patients words, with aid of pictures or videos. Difficult incomprehensible words complicate things	Dispassionate - Even though emotional involvement with sick children should be avoided but an unemotional dispassionate doctor may give a '*couldn't care less*' impression
Empathy - Doctor should try to see situation from perspective of parentss	Ego - Doctor should put his ego about his stature, and knowledge aside while counselling parents
Environment - A dedicated, quiet and calm place which provides privacy should be used	Environment - Busy corridors, wards and places with other patients should be avoided
Family/friends - All family members, who want to enquire about the status of the child, should be involved in process of counselling	Fickle-minded - Doctor should not be changing his mind frequently about the course of treatment or the outcome. This decreases faith in the team and sows the seed of doubt
Face to face - Counselling should be done face to face. Tele counselling or by use of social media must be avoided	
Genuinity - Doctor should try to give as genuine information as possible to parents	Grandiosity - Exaggeration of capabilities of surgical team or undue promises must be avoided
Honesty - Doctor should be honest, there should not be hidden agenda or interest	Hurry - Doctor should not be in a hurry while counselling, parents should be given ample time to assimilate the given information and ask any query any point of time
'Hear them out' - Listening to parents about their concerns is as important as giving them information	
Interactive - Counselling should be interactive process rather than being a monologue/lecture	Irritable - Doctor should not get irritated with queries from parents even if the same question is repeated multiple times

Each member of the treating team while dealing with parents and relatives, must imbibe the 'A to I' of Dos and Don'ts of PCiC [Table 2]. The doctor counselling the parents must be warm, empathetic, approachable, compassionate and patient towards the queries of parents. He/she must not possess a fragile ego, ignorance towards parental socio-economic and intellectual status, and an irritable attitude.

We have been applying, in principle, the concept of PCiC as part of guidelines in the training of the team, in daily clinical practice and have achieved extremely satisfying and rewarding results. We do realise that each team of doctors, physicians and surgeons have their own ways and methods of counselling attendants and parents. We have intended to share our decade-long experience with managing the attendants and parents of thousands of sick children with zero legal litigation.

The strengths of the study were, first, PCiC is an unique and novel concept, second, the multicentric prospective design, third, the large sample size and fourth, the participant cohort included all paediatric surgery patients whether managed surgically or conservatively. As the data about scrimmages and medico-legal litigations against doctors before our study was not available, we could not compare and derive a comparative result. This serves as the limitation of our study and paves a path for future case–control studies for the application and validity of PCiC. However, the data from the previous studies were put forth for comparison.

Conclusions

PCiC, being a novel concept, should form a centerpiece of paediatric surgical management as it maximally enhances the patient satisfaction level and protects the treating paediatric surgical team from scrimmage and medico-legal litigations. We found that due to the easy reproducibility of this concept, it can be easily adopted by all paediatricians as well. Furthermore, after the implementation of PCiC, the incidence of scrimmage and medico-legal litigations was drastically reduced. With rising violence against paediatric surgeons and paediatricians, we propose that it is necessary to include soft skills along the lines of PCiC into the curriculum of paediatric medicine and training of residents and young practicing specialists. PCiC also helps the parents to accept adverse outcomes of paediatric surgeries in terms of complications, morbidity and even grieve peacefully when there is mortality.

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Conflicts of interest

There are no conflicts of interest.

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