

Children's stories: A GP perspective

Lesley Morrison
General Practitioner
Scottish Borders

The actor Samantha Morton has just directed her first film about a girl growing up in a children's home, which Samantha Morton did herself. She has just spoken publicly about her criminal conviction, while in the home, for the attempted murder of someone who harassed and provoked her consistently. She spoke out because she has been so affected by the recent Commons Select Committee report (2009) which warned that the state is failing to adequately protect children in care from sexual exploitation, homelessness and falling into crime, and concluded that there had to be greater investment in children in care.

There also needs to be greater investment in the processes by which children are identified as being at risk and needing to be taken into care. In some families, the warning lights flash pretty brightly. When a young male patient starts the consultation by saying, as one did the other day *'I've got a bairn and a habit'*, your child protection antennae quickly become active. The medical student with whom I was working was fairly unsympathetic towards him until I explained that he had suffered a very emotionally deprived upbringing with an alcoholic mother. At least he was acknowledging his problem and asking for help. Whether his child continues to live with him and his partner remains to be seen.

In general practice, over several consultations and years, we acquire pieces of the jigsaw of a person, their family, their place in the community, and gradually build up a picture of them. We hear their stories and share their life events. The importance of narrative-based medicine is recognised, especially as a balance to the evidence-based, scientific medicine which has tended to dominate. The pendulum between the art and science of medicine is swinging to a more central position. When more and more of our work is computer-based and increasing importance is attached to measurable criteria for assessing performance (and pay), continuing to listen to and value people's stories is essential.

Nowhere is this more relevant than in dealing with children and young people who are looked after away from home. Sadly, chapters of the story are often missing. Patients' notes can take a frustratingly long time to catch up with them when they move home. In the case of children and young people who experience multiple sequential placements, it can be even more frustrating; for us, for them, and for their carers. The likelihood of poor health outcomes is greatly increased if the failure to attend follow-up appointments or act on

investigation results is not recognised and acted on by GPs. The ability to gain a true picture of the young person can be compromised. Research shows that these young people, as we know, are at higher risk of developing drug and alcohol problems, have poorer sexual health, a rate of smoking four times the national average and lower nutrition levels (Rodrigues, 2004). In order to make sense, not just of their full blood count, but also of their anger and behaviour, we need the narrative.

Sometimes, the narrative is hard to reconcile with the young person you have got to know. One adolescent foster child I look after is kind, bright, sensitive and a very promising musician. Her meticulous childhood notes which have followed her tell the story of an alcoholic, incapable mother with desperately deprived and at-risk children. The children were rescued by social services and given a life. Robert Frost's famous poem, *The road not taken* (1920) gives beautiful expression to such times; it describes the divergence of two possible paths in a life, the decision point which determines the future.

*Two roads diverged in a wood, and I—
I took the one less traveled by,
And that has made all the difference.*

The part of our work involved with carrying out medicals on prospective foster carers can also throw up surprises and illustrate the importance of listening to the story. Last week, I saw a young woman who was a prospective foster carer. From reading her notes, she had not had an easy life and she walked into my consulting room clearly tense and irritable at being kept waiting. I inwardly questioned whether someone whose patience was so easily strained had the temperament to foster. By the end of half an hour, having experienced her warmth, honesty and quirky sense of humour, I had no doubt about recommending her. Would she mollycoddle her charges? No. Would they be treated as ordinary members of the family and allowed to experience normal life and normal risks? Yes.

Most young people who are looked after away from home struggle to believe that they will be trusted and treated with respect and confidentiality when they engage with services, including health services. The message, 'Here to listen, not to tell', is one which we need to constantly reinforce. Young people in the care system often have to relate to so many people and agencies who communicate with each other about them that it can be especially difficult for them to believe that what they say to their GP will be private and confidential. A relationship of trust can take a long time to develop and it can be easily broken. However, such a relationship, of listening, trust and above all, valuing stories is one which general practice should strive for and continue to offer.

References

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