2. The clinical process

2.1 Assessment/course of action uses a clearly defined clinical approach, which is neither linear nor static, nor set in time. It is, on the contrary, circular and constantly shifting, adapting to the pace of each meeting and evolving over time, while always taking into account the child's and the family's situation. There are two types of assessment/course of action: the initial meeting and the follow-up/accompaniment meetings. Both follow the same clinical process.

The clinical process is divided into the following steps:

2.1.1 Welcoming children: In community social pediatrics, the welcoming children phase is the first opportunity to get to know the family and to introduce them to the clinic's services. It is vital because it is the first contact between the child, the family, any other significant adults and the community social pediatrics team.

The first contact implies two interrelated elements: accessibility, that is, how easy it is to get access to services and the actual use of services by those who could directly benefit from them (Starfield 1994). Several factors have an impact on whether or not services are used. On top of the nature of the services themselves and the resources available to the people who might use them, it is important to consider whether users want or are ready to use the services. That depends on attitudes, knowledge about health and each person's own cultural definitions of illness (Anday and Andersen 1974). It is for this reason that welcoming children plays a key role in community social pediatrics practice: it acts as a bridge between the desire to receive services and actually getting them. This is the first point at which the know-how developed within this model of integrated social medicine comes into play, and leads to a radically different way of providing services than the conventional medical approach.

In practical terms, the people in charge of welcoming children and the clinical team (physician and clinical assistant) are responsible for greeting all participants in the assessment/course of action phase. They take time to welcome the family and give them whatever attention is needed. The people in charge of welcoming children play a key role at this stage. They need to fully understand the neighbourhood and be able to really grasp local and individual behaviour codes so they can better engage and communicate with the family.

They greet the family, confirm the appointment and can begin chatting about the family's day, the children or anything else relevant to the family's everyday life.[1] They don't necessarily stay seated when welcoming the family; on the contrary, they get up, walk around and talk with people as they arrive. Moving around is very important in community social pediatrics, right from the welcoming children phase. The people greeting the children and their families serve a dual purpose: the first is to establish initial contact and the second is to explain how community social pediatrics works. If a child, parent or any member of the family, social or institutional network is not familiar with community social pediatrics or the way it operates, the people welcoming children take the time to answer their questions. Their role is to reassure and put everyone at ease. Sometimes there is no particular topic of discussion, but the reception area itself (the physical layout) is designed to make the child and his or her family comfortable. The room is set up to evoke familiar surroundings with a T.V., a couch and a refrigerator; fruit, toys and books are all available, and photos and children's drawings decorate the walls. It is important to remember that the child is not in his or her own space and that the familiar environment is intended to make sure the child does not feel intimidated

[1] The medical insurance card is only requested following the meeting or the clinical assistant may take down the information during the meeting.

by this new place. For this reason, a relaxed atmosphere and a caring approach are two integral parts of the welcoming children phase.

The community social pediatrics team always comes out to the reception area to greet the family before the meeting. The physician first speaks to the child, crouching down to be at the same level, looking him or her straight in the eye and speaking in an informal tone. This is a simple, friendly and forthright way for both of them to establish a first contact. Connections are made using both verbal and non-verbal language; this is the first step towards developing reciprocity and at the same time, provides the doctor with the opportunity to begin to subtly assess the child (based on verbal and non-verbal language). At the same time, the clinical assistant greets and welcomes the family and the other participants in the meeting (neighbours, teachers, other professionals, significant adults, etc.). A discussion ensues involving many voices speaking at the same time, much like when a family has company over. This is a key element intended to put all meeting participants at ease right from the very start. This informal atmosphere, free of institutional constraints will make it easier to ensure that the child and family continue to come to the community social pediatrics clinic and use its services.

2.1.2 Starting the meeting and introducing the participants: Following the welcoming children phase, all the participants are asked to come into the clinical area, which looks just like a dining room. Everyone – the community social pediatrics team, the child, family and other participants – takes a seat around a table, just like in someone's kitchen. This way, a friendly atmosphere conducive to sharing is created even before the meeting begins. The French proverb "the table is friendship's matchmaker" has proven to be true at the clinic, where the table helps to create a sort of "caring huddle". The mood is set for the start of the meeting, which is just as informal. The physician and the clinical assistant sit next to each other. The physician opens the meeting by asking the child if he or she knows

everyone around the table. Each person then introduces him or herself. It sometimes happens that the physician or the clinical assistant explains to the child and family that in community social pediatrics everyone sits around a table to make talking easier and to meet the child's needs more effectively. The physician or the clinical assistant also invites the child or the children to eat the fruit and play around the room whenever they want. As stated previously, moving around is an integral part of the community social pediatrics approach. This informality puts participants at ease by trying to recreate a dynamic that is as familiar as possible. Once the introductions have been made, the clinical meeting begins.

2.1.3 Information sharing: This step is not linear; it follows the conversation's natural flow and is designed to share information, to understand the child's and the family's situation and to go into more depth on certain points. It is not data collection, but rather a way of exchanging information which, in the words of psychiatrist Guy Ausloos, "provides enough information for the family to better understand the way they do things. At the end of the meeting, this is often expressed through statements such as: 'We have never been able to talk to each other like this before' or 'We said things that we have never said before'" (Ausloos 2010, p. 160). This discussion is a way of shedding light on the following points:

The reason for the consultation and the family's request: The first part of the meeting is designed to understand the reason for the visit and really grasp the family's request. The physician is the one who usually opens the discussion with the reason for the consultation. That being said, several reasons often become apparent without the physician even asking the question. The doctor and the clinical assistant leave lots of room for discussion, since the information being disclosed helps other participants join in and allows the reasons for the visit to emerge from the group itself. Participants add other useful points, thereby providing a more complete picture of the request (coming from the family), the

referral (coming from a third party or a government institution) or the court order (given by an authorized judicial body) (Mongeau, Asselin and Roy 2007). The social pediatrics team often works with families who do not have clearly articulated or explicit requests, which is why it is especially important to take the time to clarify the situation together during the various assessment/course of action meetings.

The child also plays an important role during this phase. The physician includes him or her by asking simple questions such as: "Do you know why you are here?", "Do you know why your Mum said …?" or "Is it true that you don't like school?". The physician tries to make links with what the other participants have said or tries to address questions to several participants, which enables information to come out from everyone in the group. In this sense, the community social pediatrics team also acts as facilitator. The children explain their situation in their own words, while sharing more information. The key to this question-answer dynamic is to create a dialogue connecting several people, rather than conducting a one-on-one examination. The point is to let the family further explore its own situation, not to attempt to figure out the situation on the family's behalf. It is especially important to vary the pace of the meeting and avoid the trap of monotonous dialogue. Moving around, informality, silence and, particularly, pointed or provocative questions are communication tools that help to change the meeting's tempo. The clinical assistant plays a pivotal role by making appropriate links between the diverse perceptions of the situation formed by the various agencies or professionals, and a more accurate understanding of the family's appeal or requests.[2]

Complete history and analysis of problem areas: The doctor takes a complete history during this discussion, not in the usual linear way but by following the flow

[2]It is important to recognize that the analysis of the family's requests does not end with this assessment/course of action meeting; it continues throughout the follow-up meetings.

of the conversation. The doctor's objective is to trace the medical, social and developmental history of the child, as well as his or her past medical, surgical and, most importantly, family and social experiences. The idea is to try to understand the meaning of what the child has lived through. This complete history needs to go beyond listing the child's previous illnesses or identifying symptoms. The goal is to paint a complete picture of the child's trajectory, and to identify sources of stress in his or her physical and social environment. The clinical assistant intervenes whenever necessary, just like the other participants, so that a common understanding of the family's problem areas can be reached.

Highlighting needs, rights violations, and identifying strengths in the child, family and community: As the discussion continues, both the child's needs (physical, social, emotional, intellectual, spiritual and cultural) and rights that are being denied become clearer. In addition, the discussion serves to identify and underscore strengths within the child, the family and the community, which is a way of reinforcing their resilience. By emphasizing the strengths each child and family possesses, this approach goes beyond focusing solely on problems. This information-sharing process is key to creating a bond between the child, the family and the community social pediatrics team. Its real purpose is to get to know each other; diagnosing the problem is secondary at this stage. The team will arrive at a diagnosis in time, over several follow-up assessment/course of action meetings. Note that discussions around learning and how the child is doing in school, appetite, sleep, communication patterns, behaviour, fine and gross motor skills, and sensory development figure predominantly during the meeting.

2.1.4 Physical examination and continuing the psychosocial assessment: The physical examination by the doctor is a key moment during the meeting because it causes

a change of pace.. The doctor takes the child to the examining table[3] while the clinical assistant stays with the other participants around the table. Parallel discussions then begin with the dual purpose of getting a better sense of the child's needs (the doctor with the child) and better understanding the family dynamic (the clinical assistant with the other participants). Despite the separate physical locations (examining table and kitchen table), the doctor can intervene to discuss certain points or ask questions to the family, and vice versa. The discussion continues to be informal, open and horizontal.

The physician goes beyond the conventional clinical examination (inspection, palpation, percussion and auscultation). Using this opportunity to get close to the child, he or she looks for other clues to complete the analysis. The examining table serves a triple purpose: it is a place for telling stories, revealing secrets and clinical assessment. It is sort of a world apart from the clinic, separated by a curtain for privacy and to foster a trusting relationship between the doctor and the child. To help build trust, the doctor can crouch down to check the child's reflexes. This simple gesture shows the child that the relationship is one-on-one and that they are equals. A parent or other significant adult can be present if the child feels nervous or afraid. This can also be a way of including the family network and observing the parent-child relationship, especially during key moments such as when the child's weight and height are measured.

With younger children, all the auscultation instruments are seen as toys to be played with: hammer, the effect of light from the instruments on the child's fingers, the instrument that measures blood pressure, etc. Other material in the room such as paper, pencils, books, toys, etc. can also be used to assess the child's development. In this way, the doctor decodes the messages behind the child's

[3]The family, including brothers and sisters, are free to observe the clinical examination and they frequently participate at one moment or another.

actions, while asking short, subtle questions about nightmares, friends, teachers, parents, brothers and sisters, the child's interests, etc. In the case of babies, non-verbal communication (gestures and behaviour) is fundamental during the physical examination. As Thomas Berry Brazelton, pediatrician and former Director of the Child Development Unit at Boston Children's Hospital, explains, people don't realize "just how competent babies are. They can coordinate four of the midbrain's reflexes to control themselves, and to be able to look at and listen to the people around them. They can turn their heads to one side, have neck reflexes, can bring their hands to their mouths to suck their thumbs and can follow something with their eyes. And then, you can see their faces glow with satisfaction: 'Hey! I managed to control myself, so now I am ready to get to know the world'" (Brazelton and Martino 1990, p. 35). The doctor broaches topics with teenagers openly, such as puberty, relationships, drug and alcohol use, among others.

Throughout the clinical examination, the physician continues to ask questions to better understand the child's reality and living situation. The small space means that the doctor and the child are physically close to one other, and the question-assertion format is a way for both parties to confide in each other and for the doctor to learn more about the child's opinions and reactions to what has been said previously during the meeting. The doctor needs to have excellent active listening skills.

During this time, the clinical assistant stays with the other participants and initiates an open-ended discussion to make a more complete assessment and validate or refute certain hypotheses right from this initial meeting. The main objective is to gain a better understanding of what triggered the request, the family's situation both socially and in terms of relationships: the family network, family income, housing, the family's perception of health, problems between the

parents, where the child fits into the family unit, etc., and how the child is doing in school. The discussion remains informal and focused on sharing information among all participants.

2.1.5 Working together to develop hypotheses[4] and possible solutions: Following an exchange of information to connect what was said at the examining table and at the discussion table, secrets or important information may come out. After getting permission from the child and the family to share that information with the other participants, everyone around the table is in a position to formulate hypotheses and propose solutions that may be more appropriate to the situation. At this stage, it is crucial to identify problem areas in front of all the participants because this leads to a common and shared understanding of the child's and family's experiences in a totally transparent and honest way.

This is an important stage in the meeting because everyone teams up as equal partners[5] (the community social pediatrics team, as well as the various partners from the family, social and institutional networks). "Working from an initial hypothesis means beginning a trial and error process, which is quite valid because through it, we are able to understand better which aspects of the situation are problematic" (Pauzé and Roy cited in Mongeau, Asselin and Roy 2007, p). Working together to develop hypotheses « *consiste à agir de façon sensée et organisée, à partir des besoins bien identifiés and des valeurs propres à l'individu et à sa famille*. » (Julien 2004, p). In actual practice, the discussion often provides an opportunity for family members *themselves* to discover or see the importance of certain unrecognized issues and suggest solutions that meet their needs. The

[4]The way to find solutions and be open to change. « Une supposition non prouvée, acceptée à l'essai comme base pour une investigation ultérieure. » (Selvini et al. 1982)

5In community social pediatrics, information needs to circulate freely among all participants. That being said, in certain specific circumstances, the parent or the child can ask to leave the room to speak privately with the doctor or the clinical assistant.

other participants are there to help the family make the solutions workable or suggest other possibilities.

The family is an active participant in this hypothesis-development stage, thus giving it the chance to become aware of its own problems without being judged. Rather than being among "experts", the family is an equal partner in the whole process, during which a sort of collective intelligence emerges with the doctor or the clinical assistant there at the helm.

2.1.6 Analysing, summarizing and next steps: Once the ideas for possible solutions have been suggested, the community social pediatrics team summarizes the various options brought up during the discussion. The doctor then establishes a diagnosis or a pre-diagnosis of health-related issues and an action plan is drawn up using agreed-upon priorities. The diagnosis may become clearer as time goes on, depending on the child's lifecourse trajectory. The community social pediatrics physician does not need to come up with a clear diagnosis for the child right from the first meetings. On the contrary: caution, patience and a more comprehensive understanding of health are needed, given the complexity of most family situations. The effectiveness of this type of health care can only be measured in the long term.

The action plan includes: a list of the most important needs to be looked into; an inventory of major strengths in the child, family and community; the services provided by the community social pediatrics centre (use of local resources) or referrals to external agencies through partnerships or service corridors (investigation, referral) (Julien 2004); and drug therapy. Generally speaking, the physician spells out the plan and makes sure that all participants fully understand everyone's responsibilities.

2.1.7 Confirming expectations and concluding: As is the case with all visits or rituals, there is also a closing scene. The meeting ends when solutions or potential solutions have been found in response to the issues that have been raised during the meeting. Before everyone leaves, the doctor checks whether people's expectations have been met by asking simple questions such as: "Do you have any other questions?" or "Are you happy (child's name)?". The child is then ready to leave, motivated to repeat the experience knowing that concrete steps will be taken that are adapted to his or her reality. In community social pediatrics, "concluding" signals the transition between the end of the meeting and follow-up in the medium term. In the same way as when the family and the child are greeted, the team always speaks frankly, and in simple and friendly terms. The child is always the star, and the one receiving the most attention during the goodbyes. The doctor always ends by positively reinforcing one of the child's strengths: "You're pretty!", "You're a big boy!", "You're really strong!". Often during the first visit, the community social pediatrics team gives a symbolic gift to the child as a way of making him or her happy. The present symbolizes the start of a special relationship between the child and the professional team.

2.2 The clinical process is now over, but it is really the first step in a service continuum that will be provided throughout the child's development and that follows his or her lifecourse trajectory. For this reason, two types of assessment/course of action have been put in place: the initial meeting and follow-up/accompaniment. This second type of assessment/course of action is intended to see first and foremost what progress has been made on the plan determined during the first meeting and to make any necessary adjustments as the child's needs change. This overall assessment process works because all the major players in the child's life are involved, and because of an approach that is an integral part of the way the community social pediatrics team (doctor and clinical assistant) works, which we call collaborative intervention.

References

Ackoff, R.L. 1981. *Creating the Corporate Future*.New York: Wiley.

Ackoff, R.L. 1989. "The Circular Organization: An Update." *Academy of Management Executive* 3(1): 11-16.

Ackoff, R.L. 1994. *The Democratic Corporation*, New York: Oxford University Press.

American Academy of Pediatrics. Committee on Psychosocial Aspects of Child and Family Health, Committee on Early Childhood, Adoption, and Dependent Care, and Section on Developmental and Behavioral Pediatrics, A.S. Garner, J.P. Shonkoff, B.S. Siegel, M.I. Dobbins, M.F. Earls, L. McGuinn, J. Pascoe, and D.L. Wood. 2012. "Early Childhood Adversity, Toxic Stress, and the Role of the Pediatrician: Translating Developmental Science Into Lifelong Health." *Pediatrics* 129(1): e225.

American Holistic Medical Association. 2013. Holistic medicine, what is holistic medicine? Retrieved August 26, 2014. <http://www.holisticmedicine.org/content.asp?pl=2&contentid=2>.

Aday, L. and R. Andersen. 1974. "A Framework for the Study of Access to Medical Care." *Health Services Research* 9(3): 208-220.

Ausloos, G. 2010. *La compétence des familles. Temps, chaos, processus*. Toulouse: Editions Eres.

Bass, M. 2010. Évaluation des besoins de l'enfant ou évaluation des problèmes : passer d'une démarche technobureaucratie d'expert à un système de coopération équitable, le rôle du cadre dans assessment des situations préoccupantes, ENACT d'Angers-France. Retrieved August 26, 2014. <http://90plan.ovh.net/~afresc/spip.php?article227>.

Bateson, G. 1979. Mind and Nature, A Necessary Unit. Toronto: Bantam Books.

Bateson, G. 1972. *Steps to an Ecology of Mind: Collected Essays in Anthropology, Psychiatry, Evolution, and Epistemology*. New York: Ballantine Books.

Brazelton, T.B. and B. Martino. 1990. "Le bébé : partenaire dans l'interaction parents-enfants." *Enfance* 43(1-2): 33-38.

Canadian Paediatric Society. 2004. "Treatment decisions regarding infants, children and adolescents." *Paediatrics & Child Health* 9(2): 99-103.

Center on the Developing Child 2013. How Early Experiences Get into the Body: a Biodevelopmental Framework, Harvard, graphic design Nancy Lynn Goldberg. Retrieved August 26, 2014. <www.developingchild.harvard.edu>.

Endenburg, G. 1992. *Sociocratie als Sociaal Ontwerp*, Eburon, Delft (Netherlands).

Endenburg,G. 1988. *Sociocracy: The Organization of Decision-Making*. Sociocratic Center, Rotterdam (Netherlands).

Fleuridas, C., T. Nelson and D. Rosenthal. 1986. "The Evolution of Circular Questions: Training Family Therapists." *Journal of Marital and Family Therapy* 12(2): 113-127.

Justome, S. 2010. *La co-intervention : l'apport des « RAR 2006-2010 » : journée de formation de l'Éducation Nationale Enseignement Supérieure and Recherche*. Bordeaux (France): CAREC Académie de Bordeaux. Retrieved August 26, 2014. < *http://carec.ac-bordeaux.fr/RAR/cointerventionenRARBdx.pdf>.*

Julien, G. 2007. "Une pédiatrie équitable." *Paediatrics & Child Health* 12(8): 709.

Julien, G. 2004. *A Different Kind of Care: The Social Pediatrics Approach.* Montreal: McGill-Queen's University Press.

Kittler, A. 2006. "Book review, A Different Kind of Doctor: Seeking Social Justice Through Medecine."*McGill Journal of Medicine* 9(1): 79.

Luc, E. 2010. Shared leadership : modèle d'apprentissage and d'actualisation (2eédition revue and augmentée). Montréal: Presses de l'Université de Montréal.

Mongeau, S., P. Asselin andL. Roy. 2007. "L'intervention clinique avec les familles et les proches en travail social, pour une prise en compte de la complexité." In *Problèmes sociaux : théories et méthodologies de l'intervention sociale, Tome IV.* Montreal: Presses de l'Université du Québec: 187-214.

Morris, D. 1977. *Manwatching, a Field to Human Behavior*. New York: Harry N. Abrams.

Romme, A.G.L. 1997. *Work, Authority and Participation: The Scenario of Circular Organizing*. Netherlands Institute of Business Organization and Strategy Research.

Romme, A.G.L. 1996a. "A Note On the Hierarchy-Team Debate." *Strategic Management Journal* 17(5): 411-417.

Romme, A.G.L. 1996b. "Making Organizational Learning Work: Consent and Double Linking Between Circles." *European Management Journal* 14(1): 69-75.

Selvini Palazzoli, M., L. Boscolo,G. Cecchinand G. Prata. 1980. “Hypothesizing-Circularity-Neutrality: Three Guidelines for the Conductor of the Session.” *Family Process*19(1): 3 -12.

Seywert, F. 1993. “Le questionnement circulaire.” *Thérapie familiale* 14(1): 73-88.

Social Medicine 2007. *Abstracts from the Social Medicine Session at the 2006 Annual Meeting of the American Association of Medical Colleges, Seattle* 2(1): 56-64.

Starfield, B. 1994. “Is Primary Care Essential?” *The Lancet* 344(8930): 1129-1133.

Steinmetz, N. 2010. “The Development of Children and the Health of Societies: Commentary.” *Paediatrics & Child Health* 15(1): 11-12.

Trudel, H. 2013. “Making the Convention on the Rights of the Child part of our practice.” In *Working Together to Reduce the Impact of Toxic Stress on the Child: 2nd Community Social Pediatrics Symposium*. April 12, 2013.

Trudel, H. 2010. Présentation du cœur du modèle, diapositive mobilisation et concertation, *2nd Community Social Pediatrics Symposium*. April 12, 2013.

Van Vlissingen, R.F. 1991. “A Management System Based on Consent, Human Systems.” *Management* 10: 149-154.

Zuckerman, B. 2012. “Medicine and Law: New Opportunities to Close the Disparity Gap.” *Pediatrics* 130(5): 943-944.