Original Article

Respiratory and Gastrointestinal Diseases in Pediatrics: How do Parents handle them at Home?

Enfermedades respiratorias y gastrointestinales en pediatría: ¿cómo las manejan los padres en casa?

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Summary

Objective: to identify how caregivers of pediatric patients handle respiratory and gastrointestinal symptoms and analyze different aspects such as their rooting and safety; as well as the possible impact of such practices on communication between caregivers and pediatricians. **Methods:** a qualitative, narrative study conducted at the Roosevelt Institute in Bogota, Colombia, through twelve interviews with caregivers of hospitalized pediatric patients who were having respiratory or gastrointestinal acute symptomatology. It was inquired the initial handling of the symptoms and their experience in sharing these practices with the treating physician. **Results:** the interviewed group included caregivers between the ages of 20 and 42, with different levels of school education; it was found variability of response in the type of treatments to attend respiratory and gastrointestinal symptoms. Within this variability, beneficial, safe or risky practices were identified for the management of these symptoms. Regarding communication, most caregivers feel that the physician does not provide a space to talk about it and if doing so they found rejection. **Conclusions:** some caregivers' practices coincide with medical posture, and other practices, that should be corrected, were at high risk for children. The caregivers' narrative needs to be integrated and validated to reduce dangerous practices that put children's health at risk.

Keywords: Child Care, Diarrhea, Fever, Vomiting, Communication, Ambulatory Care

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Resumen

Objetivo: identificar cómo los cuidadores de pacientes pediátricos manejan los síntomas respiratorios y gastrointestinales y analizar diferentes aspectos como su arraigo y seguridad; también el posible impacto de dichas prácticas en la comunicación entre cuidadores y pediatras. **Métodos:** se realizó un estudio cualitativo, narrativo, desarrollado en el Instituto Roosevelt en Bogotá, Colombia, a través de doce entrevistas a cuidadores de pacientes pediátricos hospitalizados que cursaban con sintomatología respiratoria o gastrointestinal de forma aguda. Se indagó sobre el manejo inicial a dichos síntomas y su experiencia al compartir dichas prácticas con el médico tratante. **Resultados:** el grupo entrevistado incluyó cuidadores entre los veinte y los 42 años, con diferentes niveles de escolaridad; se encontró una variabilidad en el tipo de tratamientos para atender los síntomas respiratorios y gastrointestinales. Dentro de esta variabilidad se identificaron prácticas benéficas, inocuas o riesgosas para el manejo de los síntomas señalados. Respecto a la comunicación, la mayoría de los cuidadores sienten que el médico no brinda un espacio para hablar del tema y en caso de hacerlo hubo un rechazo. **Conclusiones:** se hallaron, por parte de los cuidadores, prácticas que coinciden con la postura médica, pero otras prácticas tenían alto riesgo para los menores y se deben corregir. Es necesario integrar y validar la narrativa del cuidador para disminuir prácticas peligrosas que pongan en riesgo la salud de los menores.

Palabras clave: puericultura, diarrea, fiebre, vómito, comunicación, atención ambulatoria

Introduction

In the pediatric population between one and five years of age, respiratory and gastrointestinal diseases are the most prevalent infections, and represent a major cause of morbidity in early childhood. The initial handling of symptoms in these diseases is usually done by caregivers at home, and is determined by a variety of cultural, social and individual aspects which are present in the disease and treatment.[1, 2]

The model of social representations is a theory that tries to define how "knowledge of common sense, or natural thinking, is forged, as opposed to scientific thought".[3] Social representations are socially constructed and modifiable concepts according to personal experience, socioeconomic, academic or historical environments in which a person develops, and can influence people's behavior when facing health and disease processes.[2,4-6]

Social representations are sometimes different and even contrary to medical concepts and can lead to an erroneous diagnosis, delay proper treatment or predispose to complications; this can also lead to communication and trust problems between the physician and caregiver, which can have an unfavorable impact on patient care.[7-9]

Most studies on social representations in caregivers focus on chronic diseases and palliative care, however, there is emerging literature documenting the relationship of social representations with childcare to their diet and gastrointestinal diseases[10-11] in this context, the number of studies in which caregiver practices are classified, according to the risk posed by these diseases, is scarce. There is a qualitative study conducted in Chocontá (Colombia) on childcare practices under one year old, in which it was identified that ten practices should be restructured, eight, negotiated with the caregiver and only one could be preserved, because it did not affect the integrity of infants.[12] These results indicate the importance of knowing the practices carried out by caregivers, to identify potential risky behaviors and avoid future complications, through effective communication.

Given the referred context, the objective of this research was to identify how pediatric caregivers handle respiratory and gastrointestinal symptoms and to analyze different aspects such as the rooting and safety; also the possible impact of such practices on communication between caregivers and pediatricians. The component of socialization of practices by caregiver with the physician was researched and analyzed, and this gave way to reflection on possible communication failures when exercising childcare.

Methods

A qualitative narrative research was conducted, through twelve semi-structured audiotaped interviews, which were applied to caregivers of hospitalized pediatric patients at the Roosevelt Institute, at the fourth-level care center in Bogota, Colombia; practices of the caregiver in dealing with respiratory and gastrointestinal symptoms, as well as communication with medical personnel in regard to these, were investigated.

Hospital databases were reviewed to select caregivers for short-stay inpatient, from one to five days. Caregivers were selected for acute inpatients. There was testimony from caregivers whose "common sense" knowledge of health and disease processes was contrasted with medical knowledge. The selection

was based on our interest in identifying the social representations of caregivers of the processes of health and disease. In the study of social representations, we distinguish the universe of science, which, based on scientific rules and procedures, gives rise to scientific knowledge and differs from the consensual universe of social representation. In the latter, the general public elaborates and distributes forms of knowledge that constitute the content of common sense, in agreement or in opposition to the knowledge of science.

Patients between twelve months and five years of age were chosen, who were with respiratory or gastrointestinal symptomatology in an acute manner, that were not secondary to a complication or exacerbation of some basic chronic pathology. The sample size was suspended once the responses no longer varied, reaching a saturation point. Additionally, the family members questioned were the main caregivers of the child and each of the topics was discussed regardless of the reason for hospitalization. There were no scenarios of deviation from the interview, little collaboration or complaints about the care received in the institution, so it was not necessary to exclude any interview from the study.

The interviews were audiotaped and transcribed in full, all responses were tabulated, and identifiable categories were created. The practices for the symptoms under study were investigated (cough, fever, vomiting and diarrhea), their effectiveness, other known management despite not having been practiced, the origin of such knowledge (the way the information was obtained), the possible cause or complication of fever and prevention practices. These practices were signalized, using traffic light colors, in beneficial, safe, and dangerous, after a review of the available literature. Research was also carried out on prevention practices and a common concept emerged spontaneously: the *descuajo* (a popular belief that a part of the stomach, falls due to children's constant falling usually during their first steps). In addition, aspects related to communication between the caregiver and the physician were investigated with respect to addressing this issue during the consultation.

Caregivers were explained in detail the purpose of the project and the handling of the information, ensuring its confidentiality and that there would be no post-interview impact. During the interview, the caregiver showed an interest in his knowledge, thus achieving an environment of trust in interviews. The project was approved by the hospital's ethics committee in office number 2017-017. The obtained information was shared directly with the institution and the results were not disclosed to the caregivers of the hospitalized patients.

Results

The results were structured from the assumptions of the theory of social representations as emergent constructions of popular beliefs; from this approach, those beliefs are not systematically derogated as deficient but, on the contrary, they are studied as convictions that have precise functions in the studied group. In this case, it was found that the social representations of the analyzed infectious diseases activate a series of socially transmitted resources. These actions are part of the ways in which caregivers interact with their immediate circle. It is important to point out that some practices of popular knowledge are not contrary to medical recommendations; hence the need to identify social representations and classify them according to their possibilities of being reconciled with medical knowledge.[13]

The group interviewed included caregivers between the ages of twenty and forty-two; their levels of schooling included high school, technical and professional. Table 1 describes the variability in the practices for managing fever, cough, vomiting and diarrhea described by caregivers, classified, from the scientific evidence available so far, as beneficial, safe or dangerous. Caregivers reported that most of the time these management practices resulted in improvement, however, this improvement was transient or not significant. Caregivers described other forms of management that are popular, but whose effectiveness are unknown because they have not been proved before.

It was inquired the origin of the concepts of each of the practices referred to, the vast majority cited as reference their relatives: mother, grandmother or mother-in-law, followed by concepts transmitted by neighbors and friends, teachings by medical personnel or from the Internet and YouTube videos. On all occasions, caregivers considered fever to be secondary to a viral or bacterial infectious process and described consequences for not treating it as including seizures, "stroke" or "breaking down defenses".

During the interviews, the caregivers were asked about preventive measures for respiratory and gastrointestinal illnesses, described in Table 2, which shows a m ix between oral tradition, what is taught by health personnel, and information received from the media.

In the segment of the interview referring to diarrhea, the concept of *des-*

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Table 1

	Beneficial	Harmless	Dangerous
Fever	• To give Acetaminophen • Wear fresh and light color clothes • Warm water compress in forehead, armpits and feet • Full bath shower	• Bath with soda • To put Aloe vera in armpits and abdomen • Potato, onion and lemon slices in armpits, hand and feet	• Cold water compress • Cotton with alcohol in armpits • Hot water bottle in feet • Give the child to drink coke
Vomit	• Leave him/her to vomit • Get scared and go the doctor • Oral rehydration salts	• Chicken broth/soup • Onion water • Dandelion tea or infusion • Water, garlic, coriander and onion	• Avoid dairy products • Metoclopramide**
Diarrhea	• Soft diet • Go to the doctor • Solid diet, not only liquids • Oral rehydration salts	• Pear juice • Guava juice • Aniseed water • Barley water • Banana soup • Lactose free milk • Roasted rice water • Take a bath in Gualanday water (*Jacaranda mimosifolia*)	• Smecta** • Lomotil** • Metronidazole** • Avoid dairy products • Try not to give him/her liquids • Coke and cookies • Rub him/her, masseur or healer
Coughing	• Honey • Nasal wash • Honey with citrus (lemon, orange, ginger, etc.) • Go to the doctor • Hand wash • Wrap up and avoid cold • Honey, Orange and butter	• Aloe vera juice • Willow water • Milk with thyme • Eucalyptus water • Chamomile water • Propolis syrup • Warm orange juice • Papaya seed water • Orange, butter and mint • Mango and aloe vera juice • Shark oil and orange juice • Unflavored gelatin, boiled water and mint • Panela water, ginger and lemon • Hot banana with butter	• Cough syrup • Apply Vick Vaporub** • Elderberry spray • Antihistaminic: Loratadine** Chlorphenamine** • Eucalyptus mist • Hot water mist • White egg, wine, lemon and honey

**These drugs are classified as harmful because of self-medication and possible adverse effects without supervision or adequate indication.

Table 2

Prevention of an acute diarrheal disease	Prevention of respiratory diseases	
Purging	Ginger water	Guava juice
Drops of Lomotil**	Multivitamins	Shark oil
Metronidazole**	Warm cloths	Eucalyptus mist
Garlic in fasting, before getting up, without stepping on the cold floor	Avoid dust	Fruit rich diet
Had washing	Vitamin C**	The use of a red T-shirt
Avoid dairy products	Orange juice	Avoid strong odors

**These drugs are classified as harmful because of self-medication and possible adverse effects without supervision or adequate indication.

Table 3

Definition of *descuajo*
Having one foot higher than the other
Abdominal pain and diarrhea
Very liquid diarrhea with bad odor and vomit
Very strong odor diarrhea and vomit and having one leg longer that the other and a smaller eye
Darker green or black diarrhea

cuajo (a popular belief that a part of the stomach falls due to children's constant falling usually during their first steps) emerged on the part of the caregivers to refer to an entity of popular origin to which the origin of the diarrhea is attributed; when investigating this concept, various definitions were found (table 3). There is general agreement that the appropriate treatment is to "rub" the patient or the need for a bandage at the abdominal area. The participants stated that with these two treatments they have observed improvement in the symptoms. With regard to the origin of the "fall" they refer to the fact that it occurs after a fall or a blow, due to a bad movement at birth or because something "got out of place inside".

In the final part of the interview, it was inquired the communication with the physician regarding this issue; in general, all the interviewed caregivers perceived that the physician does not provide a space to talk about the topic and, if he or she does, they felt scolded, rejected or mocked. The physician's verbal and non-verbal responses are described in Table 4.

Discussion

The prevalence of respiratory and gastrointestinal diseases in pediatric population under five years makes necessary that treating physicians to know, in addition to the pathophysiological component, the social and cultural context in which they develop, this part will depend on the good communication and confidence that can be established with caregivers. This study was able to identify 70 practices for the management of this symptomatology, eighteen prevention practices, and the responses given by the physician referred by caregivers.

The interviewed caregivers were between the ages of 20 and 42, that is, there was almost a generation of difference; however, similar practices were identified with a great cultural and family influence. Different levels of schooling were found: high school and technical, professional; but these differences did not generate particularities in care or prevention practices, since regardless of the educational level all people carried out culturally-instructed management.

The origin of the practices referred to by the caregivers is mostly attributed to relatives, it can be presumed that these are more rooted than those from other sources, since they contain a cultural and emotional burden that is important for the caregiver when taking care of the child.[8, 14]

In the literature, studies of social representations in pediatric care have shown the importance of knowing and validating the socio-cultural context when dealing with a pathology. In a study carried out in Cordoba, Argentina, regarding the relationship between social representations and healthy eating, it was concluded that eating practices cannot be attributed solely to educational problems, but that economic, cultural and social aspects must also be considered.[10] A study conducted in Bucaramanga, Colombia, on how caregivers managed acute diarrhea concluded that social characteristics, level of schooling, and the people from whom the caregiver learns influence the habits for managing diarrhea, consulting the doctor, going to the healer, and identifying dehydration.[11] Another study conducted in Chocontá, Colombia, regarding practices in the care of children under one year old identified ten practices that should be restructured because they are risky, and concluded that it is necessary to know the beliefs and practices, in order to guide mothers, so that they can continue or not with their realization without disregarding the convictions of each caregiver.[12] In this study, of the 70 practices for symptom management, it was found that 21 beneficial practices should be reinforced, 29 practices are considered safe and could be reconciled and 20 practices should be corrected to avoid complications.

With respect to fever management, the official conduct according to scientific evidence is the provision

Table 4. Doctor - Patient Communication

Physician response to caregiver management	
I do not like those remedies	Where did you get that?
That does not work	Those are myths
Who told you that?	Disdainful look
Well… you better do this	They only believe in guava juice and vitamin C
Sometime they work, you do not know how but they work	Look, you have to be smarter
Are they doctors?	Negative – scolding
You should not medicate	Who told you that you could do it?

of antipyretics such as paracetamol/acetaminophen or nonsteroidal anti-inflammatory drugs (NSAIDS) and the use of appropriate clothing, with safe adjuvant measures such as warm water compresses and increased fluid intake;[15,17] these actions were identified in a group of interviewees.

There is evidence that practices such as bathing and padding with cold water and the use of alcohol-soaked cotton are potentially harmful. In both cases, surface vasoconstriction is increased, and in the second case, there is a risk of intoxication from skin absorption of alcohol.[15] The use of a hot water bottle increases the risk of skin burns; the supply of carbonated beverages such as coke may increase dehydration because of its hyperosmolar composition,[18] and finally, the use of lemon on the skin may generate local irritation.

Additionally, there is evidence of a lack of understanding by caregivers about the origin of fever and its consequences if left untreated. For example, there are concepts such as that fever produces convulsions, "stroke" or "ends defenses", and this generates a great distress in the caregiver, belittling the beneficial effect of increased temperature. On the other hand, when caregivers believe that the only origin of the fever is the infectious processes, the self-medication of antibiotics can be favored.

As for the treatment of vomiting, potentially harmful behaviors such as self-medication with metoclopramide were identified. The official approach is hydration with oral rehydration salts, with glucose and electrolyte concentrations recommended by the World Health Organization (WHO).[18] Study participants identified this practice, in combination with safe adjuvant measures such as a soft, sugar- and fat-free diet, to restart the solid diet and not just the liquid one. Other empirically effective described practices, without large studies measuring the evidence, include guava or pear juice, roasted rice water, or barley water;[19] these can be reconciled with caregivers, as they can be considered safe at this time, as long as they do not replace officially established management. It is important to clarify that the hydration plan A includes increased liquid intake, however, consumption of fruit juices does not guarantee nutritional value and because of the high carbohydrate content may increase symptoms.[20]

Among the potentially harmful treatments mentioned by the interviewees were: the medication of metronidazole, loperamide hydrochloride or diosmectite; these should be used with caution and under medical indication. In addition, "not giving the patient fluids" or administering coke with cookies increases the risk of dehydration.[18-21] As for avoiding dairy products, recent studies do not contraindicate their consumption, especially in infants; restricting their consumption may promote dehydration or malnutrition.[18,22]

In the diarrhea segment of the interview, the concept of *descuajo* (popular belief that a part of the stomach falls due to children's constant falling usually during their first steps) as a possible cause of diarrhea emerges from the caregivers. The concept and treatment of this entity is deeply rooted in the Colombian culture, so it is advisable to assume an attitude of dialogue and education so that caregivers do not delay a timely diagnosis and treatment, which can lead to dehydration or even a complication of the condition if the symptoms correspond to a surgical abdominal pathology.[23]

In relation to coughing, the official recommendation is hydration, nasal washing and hand washing, with safe coadjutant measures such as avoiding cold currents or administering honey.[24] In the interviewed group, honey was accompanied by different foods which have not been shown to enhance the benefit of honey and, in fact, some combinations such as honey with onions can generate vomiting. Other approaches proposed by interviewees may be counterproductive, such as self-medication of antihistamines or cough syrups. With respect to the application of camphor, menthol and eucalyptus ointments, irritative effects, intoxication and even lipoid pneumonia have been described.[25]

With respect to the prevention of respiratory diseases, the practices referred to by the interviewees that coincide with the official position are hand washing, wear warm clothes, a rich vitamin C diet, orange or guava juice, and a diet rich in fruit, due to its vitamin content; avoiding dust and strong odors. Other actions such as garlic with an empty stomach, avoiding dairy products, ginger water, shark oil, or the use of red cotton T-shirts, despite the lack of studies supporting them, they are safe and should be discussed with the caregiver.

One of the most relevant aspects of the results is that, in all the interviews, the general perception that the caregivers have regarding the trust and space provided by the physician to talk about the measures taken at home is very limited. The caregivers refer to a derogatory attitude, of rejection or mockery, on the part of some physicians in the face of traditional knowledge. These attitudes diminish their dignity as caregivers and call into question their capabilities; and they do not contribute to providing them with

tools to do their job better. The most frequent reaction of caregivers to this attitude is to protect their dignity as caregivers, with attitudes such as withholding information or inadequate adherence to official treatment. This generates a fragmentation in the relationship between physician and caregiver that can affect the patient's health.[14,26]

This study could have investigated more about the cultural and social context in each interviewee to have a greater correlation between social representations and their different determinants (race, place of origin and social stratum). Another limitation was the performance in a hospitalized patient, an environment that can generate fear at the time of response. On the other hand, the collected data seem sufficient to achieve a didactic document, from which health professionals can guide their clinical practice by being attentive to the customs of the caregivers and establishing assertive forms of communication that allow better cooperation between caregivers and health professionals.

Conclusions

21 social representations considered beneficial were identified, which must be reinforced by medical staff; 20 practices are definitely risky for children and should be corrected during clinical practice; and 29 actions that, despite having no studies to support their effectiveness, are considered safe, so a conciliatory attitude must be assumed, taking advantage of the culture of care as a tool to strengthen the link between the physician and the caregiver. It emphasizes the importance of listening and showing an interest in the caregiver's narrative, in order to empower it, reduce dangerous practices, and strengthen safe practices and to not dismiss non-risky actions that do not have scientific evidence. Physicians should never assume an attitude of scolding, rejection or mockery. Physicians should strengthen caregivers for their care and care capabilities through assertive communication and a relationship of trust.

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