How are children's best interests expressed during their hospital visit?—An observational study

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Abstract

Aims and objectives: To describe ways in which children’s best interests were observed to be expressed in paediatric settings during their hospital visit.

Background: The best interests of the child are embodied in national and international legal systems, although the definition remains problematic. The child’s limited autonomy mandates duty bearers to have both a child perspective and the child’s perspective when considering what the best interest of the child entails in care situations.

Design: A qualitative descriptive study with overt, non-participant observations fulfilling the COREQ criteria.

Methods: Thirty-two observations of interactions between children aged 2 to 17 years with both acute and chronic conditions, their parents and healthcare professionals were conducted at three paediatric hospitals in Sweden. Inductive and abductive reasoning were used in the content analysis of data, which followed the identification, coding, categorising and abstraction of observed patterns of the best interest of the child.

Results: Findings reveal facilitating and obstructing factors for the child’s best interests to be safeguarded in healthcare situations. Children were guided in or hindered from exercising their competence. The observations showed a variation in actions taken by both parents and healthcare professionals to safeguard the best interests of the child.

Conclusions: Determining the best interest of the child requires a case-by-case basis, as it is context-dependent, situational, flexible and dependent on all actors involved and actual decisions made.

Relevance to clinical practice: Healthcare professionals’ actions can facilitate or obstruct observed expressions of the child’s best interest. It is essential to enhance healthcare professionals’ communication skills, knowledge awareness and continuing education about the rights of children receiving healthcare services. Reflections and discussions on how to protect the best interests of children may help healthcare professionals to uphold children’s best interest in daily clinical practice.
1 | INTRODUCTION

The best interest of the child is one of the four core tenets of the 1989 United Nations Convention on the Rights of the Child (UNCRC). Article 3, states that, ‘In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration’ (UNCRC, 1989). In accordance with the UNCRC definition of child, all persons under the age of 18 will be referred to as a child in this study. Interests are defined as ‘those things that are needed for a child’s wellbeing’ (Bester, 2019, p.120), and best interest is defined as ‘acting so as to promote maximally the good of the individual’ (Buchanan & Brook, 1990, p.88). Interests may be current or future oriented. Current interests include the child’s immediate interests (wanting pleasure, desires to be free from harm and discomfort, and normal functioning) whereas future-oriented interests refer to developmental interests of the child (Buchanan & Brook, 1990) Values codified in the declarations of the World Medical Association International Code of Medical Ethics guide healthcare professionals with the moral obligation to ensure the best interests of their patients in all care situations (World Medical Association [WMA], 2013).

2 | BACKGROUND

The best interest standard is an integral aspect in the moral foundations of medicine (Bester, 2019). In the patient-provider relationship, the moral commitments of the provider, henceforth referred to as healthcare professionals, include promoting the health, well-being and rights of their patients (World Medical Association [WMA], 2013) and not less so when the patient is a child (Buchanan and Brook, 1990). The best interests of the child can be looked at from the child’s perspective, which gives insights into the child’s perceptions and experiences of their reality whilst the child perspective reflects the adult’s understanding of children’s perceptions (Sommer et al., 2010). The best interests of the child can also be understood through the lenses of child-centred care (CCC), a philosophy of care that places the interests of children at the core of care planning and delivery (Coyne et al., 2014). Underpinning the best interest standard in CCC is an acknowledgement of the competing interests of parents and healthcare professionals to those of children, and to determine which interests promote the net benefit for the child (Buchanan and Brook, 1990). This presupposes that opportunities are created for children to express themselves and be listened to (Carter et al., 2014). The best interest standard accords a central focus on the individual’s current and future-oriented interests and this resonates with CCC, which offers a holistic view of children beyond their current illness (Ford et al., 2018).

The holistic view of children can further be appreciated by insights from Bronfenbrenner’s bioecological model, which affirms the central placement of an individual, in this case, the child. The developing child is at the centre in interactions with its environment, consisting of five layers: the micro, meso, exo, macro and chrono systems (Bronfenbrenner 1979). Care of sick children involves emotionally and practically complex situations. These may induce various kinds of emotional responses such as fear (Leibring & Andersén-Carlsson, 2019) and anxiety (Andersén-Carlsson, Sörrie, & Kihlgren, 2012; Delvecchio et al., 2019). The family unit, which is part of the child’s immediate environment (microsystem) in the bioecological model, plays an important role as the child undergoes an ecological transition from the micro to the exosystem. As the child navigates through and interacts with an unfamiliar environment in the healthcare setting (the exosystem), the parents are the first source of comfort and safety for the child (Delvecchio et al., 2019; Salmela et al., 2011). Knowing their child, parents play an integral role in their child’s care, aiming to maximise opportunities that foster the best interests of their children. At times, parental views of what is best for their child
may not always 'be best' for the child and so professional guidance of healthcare professionals is crucial (Coyne & Harder, 2011).

When children encounter healthcare, the attitudes and practices within the healthcare setting reflect the societal view of children (Carter et al., 2014). The needs of children in healthcare are also governed by legislation and laws (macrosystem) that aim to protect the interests of children. On January 1, 2020, the UNCRC was incorporated into national law in Sweden (2018:1197, Government Offices of Sweden, 2017). This complements and reinforces the Swedish Patient Act (Patientlagen 2014:821 [The Patient Act], 2014) which also emphasises the child's best interests. Thus, paediatric institutions have a legal duty to uphold the best interests of the child. A report by the Barnombudsmannen (2020) states that a child's right perspective in all affairs concerning children needs to be strengthened. Previous research has usually employed interviews to elicit children's voices (Anderzén-Carlsson et al., 2012; Coyne, 2006; Coyne et al., 2014; Leibring & Anderzén-Carlsson, 2019). However, observed interactions of children, parents, and healthcare professionals on how to uphold the child's best interests are less explored. There is a dearth of evidence on how the best interests of the child may be upheld in daily clinical practice (Waterston & Yilmaz, 2014) and an exploration of situations within medical and nursing care involving children, their parents and healthcare professionals may provide valuable insights in this current knowledge gap.

3 | OVERALL AIM

To describe ways in which children's best interests were observed to be expressed in paediatric settings during their hospital visit.

Specific objectives

1. To identify and describe everyday situations in medical and nursing care that illustrate ways in which the child's best interests are expressed during the child's hospital visit.
2. To identify and describe aspects of everyday medical and nursing care that facilitate or obstruct the expression of the child's best interests during their hospital visit.

4 | METHODS

4.1 | Design

This research employed a qualitative descriptive design (Sandelowski, 2000) that has its philosophical orientation in naturalistic inquiry. Data were collected by means of overt non-participant observations (Neuman, 2014). Inductive (Elo & Kyngäs, 2008) and abductive reasoning (Ericksson et al., 1997, Mirza et al., 2014) were used in the content analysis of data. The methods adhered to the Consolidated Criteria for Reporting Qualitative Studies (COREQ) (see Supplementary File 1). A detailed description of the study setting, participants and their recruitment, and the conducting of observations is provided elsewhere (Quaye et al., 2019).

4.2 | Data collection

4.2.1 | Setting

Data collection occurred over a period of eight months from 2017 to 2018. Observation sites included one paediatric regional hospital and two paediatric units at a tertiary university hospital in [country name]. Fourteen departments received an invitation to participate, with one declining due to limited resources and staffing. The departments, which included nine outpatient units (two of which were emergency units), and four inpatient units, cared for a range of conditions including orthopaedics, oncology, cardiology, diabetes, congenital malformations, surgery, plastic surgery, ear-nose-throat and ophthalmology.

4.2.2 | Participants and participant recruitment

To enable exploration of multiple realities among participants and to enhance maximum variation, children aged 2–17 years, with different diagnoses and hospital admissions were recruited, along with their parents. Six boys and five girls, along with their parents, declined to participate in the study. Reasons ranged from disinterest in the study, to sensitive diagnosis of the children which the child did not want to be observed during consultations, and parents not wanting their child with an intellectual disability to participate. Healthcare professionals observed included registered general nurses, assistant nurses and physicians, all with various levels of specialisation. The first author obtained the schedules of children who were yet to attend their healthcare appointments at the respective participating departments. Upon the child's admission, the attending nurse provided the child and parents with a short introductory letter about the study. Children and their parents who showed an interest in participating in the study informed the attending nurse, who then informed the first author. The first author then took contact with and gave age-appropriate information to interested parents and their children. Observations began when written assent and consent were obtained from both children and their parents. Healthcare professionals received information about the study through briefing sessions and posters displayed on notice boards in all the participating departments, and they were given the opportunity to opt out of study participation. Background information of the observed children is shown in Table 1.

4.2.3 | Observations

The first author followed 32 children and their parents throughout their hospital visit. The observer sat near the door, or stood in a corner of the examination room, observing everyday medical and nursing care including verbal and nonverbal interactions between the children, the healthcare professionals and their parents. Observations ranged from 25 minutes to 72 hours, with four hours
TABLE 1  Background variables of observed children included in analysis (N = 32)

<table>
<thead>
<tr>
<th>Gender (n)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Girl</td>
<td>18</td>
</tr>
<tr>
<td>Boy</td>
<td>14</td>
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<table>
<thead>
<tr>
<th>Age range (median age = 8 years)</th>
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<tbody>
<tr>
<td>2-6 years</td>
<td>13</td>
</tr>
<tr>
<td>7-11 years</td>
<td>9</td>
</tr>
<tr>
<td>12-18 years</td>
<td>10</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason for admission</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal, stomach, kidney and reproductive organ problems</td>
<td>12</td>
</tr>
<tr>
<td>Surgery for heart operation</td>
<td>5</td>
</tr>
<tr>
<td>Infection</td>
<td>6</td>
</tr>
<tr>
<td>Sleeping problems</td>
<td>2</td>
</tr>
<tr>
<td>Respiratory problems</td>
<td>1</td>
</tr>
<tr>
<td>Diabetes and cancer</td>
<td>3</td>
</tr>
<tr>
<td>Knee problems</td>
<td>1</td>
</tr>
<tr>
<td>Allergy</td>
<td>1</td>
</tr>
<tr>
<td>Blood disease</td>
<td>1</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of hospital visit</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient</td>
<td>20</td>
</tr>
<tr>
<td>Inpatient</td>
<td>12</td>
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<table>
<thead>
<tr>
<th>Length of hospitalisation</th>
<th></th>
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<tbody>
<tr>
<td>0-1 hr 59 min</td>
<td>8</td>
</tr>
<tr>
<td>2 hr-9 hr 59 min</td>
<td>8</td>
</tr>
<tr>
<td>10 hr-23 hr 59 min</td>
<td>0</td>
</tr>
<tr>
<td>24 hr-71 hr 59 min</td>
<td>5</td>
</tr>
<tr>
<td>72 hr+</td>
<td>11</td>
</tr>
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</table>

being the median length. The first author took 30-minute short breaks to record field notes for observations that lasted longer than an hour. Observations discontinued when no interactions occurred involving the children and healthcare professionals, or when the child was in play therapy, asleep, or healthcare professionals attending to a child being observed had opted out of the study, or places with entry restrictions for the observer. Data collection consisted of field notes written by the observer during each observation and transcribed into English in narrative text format.

4.3  Data analysis

Inductive reasoning in the content analysis was chosen because there is a dearth of evidence on how the best interests of the child may be upheld in daily clinical practice. This analytical approach involved identifying, coding, categorising and abstraction of observed patterns of the best interests of the child. Figure 1 shows the flowchart of the analytical process. (Elo & Kyngäs, 2008). **Step 1:** A naïve reading of the observation texts was done by the first, second and last authors to get new and deeper insights into the observations. The first author read thirty-two individual transcribed observations and field notes. The last author read 90% of the observation transcripts and the second author read 20% of the observation transcripts. **Step 2:** The first author identified 548 situations that reflected any kind of interactions between the child, healthcare professional and the parents. In **Step 3,** situations were examined in relation to the question: ‘Was the child’s best interest reflected in this situation?’ and situations containing inadequate information were omitted. Open coding of key events in each identified situation was done independently by the first, second and last authors, and verified in joint discussions. **Step 4:** Categories emerged by the rigorous examination of the identified situations and their possible meanings, by the first author and verified in joint discussions with the second and last authors. **Step 5:** An abductive reasoning was then employed, to connect the initial findings to what is written in literature. A search of past research was therefore conducted. Key references (Coyne et al., 2014; Runeson, Hallstrom, Elander, & Hermelin, 2002a; Quaye et al., 2019) found by means of manual search were identified. Reference lists of key articles were searched for further relevant studies. Searches were also conducted in the databases CINAHL Complete and PubMed using the free search terms: best interest, child’s opinion, children’s competence, child-centred care. From the retrieved articles, seven principles grounded in the literature were developed and joint discussions among all authors led to refinement of the seven principles into six principles. The numbering of the principles (shown in Table 2) does not follow any order of hierarchy. **Step 6:** The categories were discussed in relation to the six principles. Facilitators and obstructors in each category were noted. The six principles were used as a guide in grouping the categories into main categories.

4.4  Ethical considerations

The Lund Regional Research Ethics Committee (ref 2014/411) approved the study. The Helsinki Declaration, (WMA, 2013), The European Code of Conduct for Research Integrity (ALLEA, 2017) and General Data Protection Regulations (GDPR, 2018) were adhered to in the study. All heads of departments at the Children’s Hospitals approved the study. Participants were assured of confidentiality (non-disclosure of their real names and diagnosis details) and informed of their right to withdraw from the study at any time without this affecting their healthcare.

5  RESULTS

Findings are presented according to factors that facilitate or obstruct expression of the child’s best interests in healthcare situations, under three main categories: giving child-focused preparatory information, acknowledging the child’s influence, and striving to achieve a balance, and eight categories. The main categories are presented in bold text whilst the categories are italicised. Observations indicated
Identification
Joint discussions by 1st, 2nd and last authors.

“Was the child’s best interest reflected in this situation?”

5 situations omitted due to insufficient information

Open coding
Joint discussions by 1st, 2nd and last authors.

Yes
463 situations

No
80 situations

Identification and categorisations of situations
Joint discussions by 1st, 2nd and last authors.

Independent categorisation
1st author proceeded with categorisation, noting down complex situations not easy to categorise.

Independent categorisation of 155 and 129 situations by 2nd and last authors respectively.

12 situations were merged into other situations.

10 new situations resulted from the splitting of 10 situations.

Re-examination of 15 situations characterised by use of restraint.

541 situations included

FIGURE 1 The process of identifying and categorising everyday situations in nursing and medical care that illustrate the child’s best interests
that children in this study could be guided in or hindered from exercising their competence in care situations. The observations showed a variation in actions among both parents and healthcare professionals to safeguard the best interests of the child. Results are supplemented with descriptions of situations from the field notes. Table 3 below gives an overview of the categories and main categories.

5.1 Giving child-focused preparatory information

Reflected in this category are situations where children either received or did not receive preparation tailored to meet their informational needs. The former acted as facilitators enabling the expression of children’s best interests, whilst the latter presented as obstruc tors to expression of the child’s best interests. Information exchange was a prominent aspect throughout interactions between the children, their parents and healthcare professionals. Verbal information given to children was observed to be introductory, preparatory and sensory in nature. Receiving or not receiving such information facilitated or obstructed observed ways of expressing the child’s best interest. Creating time prior to a procedure, to explain things to the children and their parents, and following up with the children to see whether they understood what was explained to them enhanced observed expressions of the child’s best interests. Not creating time to give necessary information to children before procedures presented as obstructors.

5.1.1 Facilitators

*Introductory information* from healthcare professionals about who they were and what role they would play during the child's
hospital visit was given to children. Children and their parents also got the opportunity to introduce themselves to the healthcare professionals. Preparatory information was given to children prior to undergoing surgery, an examination, treatment or length of hospital stay. Children also received sensory information about what a particular treatment they were yet to undergo would feel like. In certain instances, healthcare professionals employed the use of visual aids, to help the child see instruments that would be used in his/her care.

An assistant nurse attends a 4-year-old child who is going through routine checks prior to an operation the following day. The children’s nurse shows the child a blood pressure (BP) kit. ‘Have you seen this?’ the children’s nurse asks the child. The child shakes its head from side to side...The children’s nurse explains to the child, ‘We will put this on your arm and then pump air into it, and it will feel tight around your arm and then relaxed and then tight again, and relaxed. Are you ok with that?’ The child nods its head...

\[(A14)\]

\[5.2.1 \quad \text{Facilitators}\]

Prior to undergoing routine checks or procedures requiring blood samples, children’s views were actively sought by the attending healthcare professionals. During a procedure, healthcare professionals constantly asked the children how they felt. In one situation, a 14-year-old child expressed feeling immense pain after a cannula insertion. The healthcare professionals removed the cannula and inserted it on a different arm. Older children were sometimes given the opportunity to choose if they wanted to administer the treatment by themselves, prick themselves or remove a cannula with the healthcare professionals’ supervision. Children either indicated they preferred not to do so or agreed.

An assistant nurse is about to give painkillers to a 9-year-old child. ‘Can you sit up? You will have to drink the medicine; the assistant nurse tells the child. The child sits up in the bed. The assistant nurse holds up the medicine in a syringe and asks the child, ‘Do you want me to hold it for you as you drink, or do you want to hold it for yourself?’ The child looks at the mother. The mother gestures with a nod of her head. ‘I can hold it, the child responds. The assistant nurse then gives the medicine to the child...

\[(A7)\]

\[5.1.2 \quad \text{Obstructions}\]

Challenges arose when there was a communication barrier in terms of language despite the presence of an interpreter or when children did not receive information prior to a procedure. In the example below, information about treatment alternatives was discussed with the parents and not with the child.

A 4.5-year-old child and parents are being attended to by a nurse. The nurse discusses treatment options for the child with the parents of the child. The nurse maintains eye contact with the child’s parents, informing them of the treatment alternatives. The child sits quietly, turning its head back and forth, looking at whoever is talking...

\[(A3)\]

\[5.2 \quad \text{Acknowledging the child’s influence}\]

This alludes to situations where healthcare professionals were observed to either actively seek the child’s views about their care, or not. Seeking the child’s views entailed paying attention to the child’s interests and thereupon creating space for the child’s influence. Observations showed that creating space for the child’s influence also meant that the child’s preferences and interests were given due consideration. This led to a compromise in how the planned care could proceed with the child’s interests at the centre of the care planning. However, not actively seeking the child’s views in matters concerning their care presented as obstructors.

‘Are you ready?’ a nurse asks a 14-year-old child prior to a cannula insertion a second time... ‘I am not ready, but it would take an eternity if we were to wait for me so just proceed’, the child responds. ‘I hope we will succeed this time’, the nurse says. ‘Please stop saying that. It makes me more nervous’, the child responds immediately. ‘Oh sorry’, the nurse immediately apologises...
5.2.2 | Obstructions

At times, children were not presented with opportunities to negotiate their readiness before the planned care could be carried out. Children's views were not actively sought, nor could they exercise their influence.

A 14-year-old child's feet are about to be examined by a doctor. The doctor squats by the child's side. Without asking the child, the doctor lifts the child's clothes slightly upwards. The child immediately pulls its legs backwards. The child's eyes are wide open. Eyebrows are raised. A nurse standing by purses her lips. Another doctor standing next to the nurse purses her lips and her eyes open wide. The child's grandmother looks at the child. There is a slight moment of silence...

(A4)

In addition, the feelings of children who seemed upset after undergoing stressful procedures were sometimes observed not to be given due attention by the parents or the healthcare professionals. In a situation after a procedure with the use of restraint was over, the healthcare professional said to the child, 'You are really good.' The child spoke out saying, 'I am upset.' The child's mother responded saying, 'But it wasn't so scary' and gave him a hug. The mother and child continued talking whilst the healthcare professional prepared to leave the room.

(A6)

5.3 | Striving to respect the child's abilities

Efforts were made by parents and healthcare professionals to respect the child's abilities. In the case of parents, relinquishing protective over the child implied that parents allowed their child to exercise their competence under guidance that would not obstruct expression of the child's best interest. At the same time, healthcare professionals also had to strike a balance in ways of engaging the child despite parental disruptions. Healthcare professionals made efforts to continuously include children in discussions in situations where parental involvement risked obstructing the child's best interest. In complex situations, balancing benefits against unintentional harms meant unpleasant experiences for the child to undergo. In 15 situations, restraint or holding of the child was used to prevent the child from moving so that the care could proceed.

(A29)

5.3.1 | Facilitators

Parents requested treatment alternatives for their child or asked for more time to be taken to explain a planned procedure to their child. Parents also helped children feel more secure about undergoing a procedure by going through it themselves, such as standing in front of an X-ray machine or pretending to drink medicine. At times, in the absence of the healthcare professional, children complained to their parents about painful procedures, and their parents encouraged them to talk about it with the healthcare professionals. For children with a long-term condition, parents actively took part in their care and helped to administer medication to their children by themselves. The parents allowed conversations to occur between their child and healthcare professionals, without much interruption.

5.3.2 | Obstructions

Situations also presented insights of parents constantly interrupting conversations between their child and the healthcare professional, either to have their own informational needs met or to answer...
questions on behalf of their child. At times, this led to older children being passive and not being able to take part in ongoing discussions. Balancing benefits against unintentional harms could result in the use of restraint when younger children took longer to co-operate with a planned care, and parents lost their patience. The use of restraint was not objected to by the healthcare professionals. Restraint was commonly used observed in situations such as taking a capillary blood sample, undergoing EKG and X-ray examinations, cleaning of wounds from an operation and removal of plasters.

A 6-year-old child is going to have an operation wound examined by two nurses. The mother and nurses, standing on either side of the bed, try for a while to convince the child to let the nurses have a look. The child refuses. The child covers its body with a blanket and continues to prevent the nurses from pulling it down. After a while, the mother grabs her child’s hands. She tells the nurses to go ahead. The nurses immediately pull down the blanket. The child shouts, ‘No! No, mum, no!’ The child wriggles on the bed in protest. The nurses pull down the child’s clothes. They carefully examine the wound...

(A5)

Findings demonstrated that, at times, greetings were exchanged among healthcare professionals and parents whilst children were not greeted. During discussions, disruptions from the parents caused healthcare professionals to continue the rest of the conversations with the parents and the child was side-lined. In consultations, parental views were sought more than those of children.

6 | DISCUSSION

This study found that there were both facilitating and obstructing aspects to the observed expressions of the child’s best interests. Children’s ability to exercise their influence in care was largely dependent on the actions of parents and healthcare professionals.

In this study, children receiving introductory, preparatory and sensory information about their upcoming care facilitated observed expressions of the child’s best interest. Observations revealed that children were keen to know who would meet them, what would happen to them, how procedures, treatments or examinations would feel, and this reflects their current interests. Bray, Appleton, & Sharpe (2019) also highlight these three types of information children deemed important to receive. Not receiving child-focussed preparatory information appeared to obstruct expression of the child’s best interests. Lack of information has been reported as one of many probable causes of fear as children navigate through the unfamiliar environment of the healthcare setting (ecosystem) (Salmela et al., 2011). During the ecological transition to an unfamiliar environment, children’s inadequate understanding of certain procedures may further exacerbate their fears (Salmela et al., 2011) thus meeting their informational needs is inevitable. In the present study, creating time to prepare children, explaining things to them, and following up on their understanding of what was explained to them was observed to enhance children’s knowledge of their new situation. Research shows that meeting the informational needs of children makes them feel valued and less anxious (Coyne & Gallagher, 2011; Stålberg et al., 2016), has a positive effect on their experiences of clinical procedures (Gordon et al., 2011), and ensures their rights to seek, receive and impart information from a child’s right perspective as recommended in Article 13 by the UNCRC.

In the observations, acknowledging the child’s influence reinforces placing the interests of children at the centre of care planning as stipulated by a child-centred care (CCC) approach. Allowing children to exercise their influence as seen in the findings, further mirrors respect for the child’s competence (ability to perform a task) as defined by Beuchamp and Childress (2019, p112). The child is then guided through relevant actions by the adults, to increased competence (Coyne, Hallström & Söderbäck, 2016; Ford et al., 2018), an aspect that Davies et al., (2019) point out may be one of the most challenging assumptions to overcome. It challenges the historical placement of children where an asymmetric position existed between the children and adults, and children did not enjoy equal value and rights as adults (Davies et al., 2019). Since children interact with numerous changing environments, Bronfenbrenner’s theory emphasises understanding children in these environments. Findings in this study reveal that parents and healthcare professionals made efforts to facilitate observed expressions of the child’s best interests. Actively seeing the views of children, as seen from the observations, shows that children’s roles as co-constructors are recognised. Planning care whilst being aware of children’s interests ensures that their unique perspectives are brought to light, and care can be tailored to maximise the net benefits for the children. At times, children’s views in this study were actively sought, and they were given opportunities to have influence over how the planned care could proceed. This is in synergy with a CCC approach to care planning, empowers children and makes them feel recognised. These findings support previous research (Coyne, 2006) which show that children felt they were respected as persons when their opinions were sought, and they were not just instructed on what to do. Striving to respect the child’s abilities in care situations in the observations highlights the efforts of parents and healthcare professionals to balance benefits against harm in care situations. This could further be emulated in care situations, as it shows the child’s role as an active agent in the partnerships and that a holistic view of the child as stressed by a CCC approach, is recognised (Coyne, 2016).

In our observations, obstructions to expression of the best interests of the child arose when competent children were hindered from exercising their rights in healthcare situations. Instances where striking a balance in the triadic interactions presented as an obstruction are seen in situations where healthcare professionals directed questions about children to their parents or discussed results of an examination with the parents instead of the child. These findings are in congruence with earlier research where parents were a proxy in
consultations between their child and the healthcare professionals (Coyne & Gallagher, 2011; Sahilberg, Karlsson & Darcy, 2020). At the same time, other research has discussed the challenges in striking a balance between protecting the child from too much information and acting in the best interests of the child (Martin et al., 2019). Our identified situations revealed the communication about expectations and responsibilities for the child, parent and healthcare professionals was missing, as also found by Coyne, (2015). Lack of open tailored communication involving the child, parents and healthcare professionals could lead to negative experiences of healthcare for the sick child (Coyne, 2006). In our study, balancing benefits against potential harms at times led to the use of restraint, or children being side-lined in discussions about the ongoing care. A review by Bray et al., (2015) also shows the use of holding/restraint during procedures involving children in several studies. Limited knowledge in national guidelines for procedures with use of physical holding/restraint was reported by healthcare professionals and that they also experience challenges in balancing benefits against unintentional harms where holding/restraint is concerned (Bray, Carter, & Snodin, 2016; Bray et al., 2019). Sahilberg et al., (2020) report similar findings to ours, where parents limited the opportunities for their child to be heard.

6.2 Methodological considerations

Qualitative descriptive studies allow researchers to stay close to their data and offer a broad description of observed facts about the phenomenon under study, in everyday language (Sandelowski, 2000). The use of overt, non-participant observations (Neuman, 2014) enabled the first author to visibly observe the ongoing interactions between children of different age and with different diagnoses, their parents and healthcare professionals in the hospital setting. However, the behaviour and actions of the participants may have been influenced by the presence of an observer. Observation is a technique that facilitates the capturing of tacit knowledge (non-verbal communication, artefacts, symbols or hidden cultures) that are an integral part of participants' daily lives (Dahlgren, Emmelin, & Winkvist, 2007). The trustworthiness of the observational data was enhanced by rigorous approaches to the sampling of participants, systematic and objective taking of field notes, and data analysis leading to over 500 situations identified and analysed.

An inductive approach was chosen because scientific knowledge about how the child's best interest can be upheld in the paediatric setting is fragmented (Elo & Kyngäs, 2008). Abductive reasoning enhances the development of scientific knowledge by enabling the perception and understanding of underlying meanings of a phenomenon (Erickson et al., 1997). The use of the six principles refers to the abductive reasoning in the analysis and connects the results with Articles 3 (best interest), 12 (respect of child's views) and 13 (freedom of expression) of the UNCRC (1989). The six principles need to be developed further for use in situations involving holding/restraint to also reflect the child and parent's consent, and where informational needs of parents were met. Having their informational requests met enables parents to have some level of control during this stressful period of having a sick child (Hallström et al., 2002), and therefore, this could be considered in accordance with the Patient Act in Sweden (Patient Act, 2014) when determining the child's best interests.

The first author has an educational background in molecular biology and public health, which may have presented a risk in under- or overestimation of observed situations, and subsequent analysis. As a strength, it allowed the first author a level of naïvety in data collection and analysis. The second, fourth and last authors had expert knowledge and experience, having worked as paediatric nurses and researchers in the Swedish healthcare system. The third authors' professional background and international perspective, and the different pre-understanding of all the authors added credibility to the study.

6.1 Mutual negotiations

The complexities involved in the care of children may pose challenges for healthcare professionals to uphold the child's best interests. To promote the child's best interests, healthcare professionals could take the responsibility to initiate/encourage mutual negotiations involving the child, parents and healthcare professionals. In mutual negotiations, the child, parents and healthcare professionals are all experts in their own rights, albeit with varying levels of competence and experiences (Harder et al., 2013; Rogoff, 1990). The approach of mutual negotiations seems not to be commonly used in clinical practice (Harder et al., 2013), even though negotiations are often a daily part of children's interactions in the home, and other environments (Rogoff, 1990). Harder et al., (2013) posit that encouraging negotiations improves children's autonomy and competence when they interact with people in new environments. When competing interests of the actors involved arise, a more holistic view of the child and situation as supported by CCC and the bioecological approaches may enhance understanding. An ecological view would allow understanding of the child's immediate support system (microsystem) such as the disruptions the child and parents are facing and how this could be affecting their coping strategies and response to care. From a CCC perspective, the important questions are finding out what the current and future interests of the child (child's perspective), parents, and healthcare professionals (child perspective) are, and how may the healthcare professionals engage the child and parents, and together weigh the competing interests against alternatives, reaching a compromise that promotes the best interests of the child. Inclusion of both the child's perspective and a child perspective is crucial in the mutual negotiations (Söderbäck et al., 2011). When parental views of what may be good for the child risk causing more harm than good, such as situations where restraint is suggested by parents, healthcare professionals should advocate on behalf of the child, with a child's rights perspective (Waterston & Yilmaz, 2014).
7 | CONCLUSION

The study offers a new understanding of what aspects of medical and nursing care may facilitate or obstruct expression of the best interests of the child. The former should be encouraged in paediatric care and the latter should be discussed and reflected upon for alternative solutions. The best interests of the child (Article 3) are interwoven into all the other rights of the child in the UNCRC, which also needs to be taken into consideration when determining what is best for the child (Degol & Dinku, 2011). Determining the best interests of the child requires a case-by-case basis, as it is context-dependent, situational, flexible, dependent on all the actors involved at a particular moment, and actual decisions made. Mutual negotiations involving the child, parents and healthcare professionals should be encouraged, as negotiations help increase the child’s competence. It may be suggested that different values and experiences of children, their parents and healthcare professionals could present diversity in safeguarding the child’s best interests (Bowyer, 2016; Dan, 2018), thus possibly accounting for variations in expressions of the best interests of the child. Therefore, future research should focus on examining whether various levels of specialisation among healthcare professionals play a role in facilitating expression of the child’s best interests. Further observations coupled with interviews of children, their parents and healthcare professionals may give a deeper understanding of their perceptions and experiences of the best interests of the child.

8 | RELEVANCE TO CLINICAL PRACTICE

A continued creation of knowledge awareness of what the rights of children are when children encounter healthcare services is important. Fulfilling the best interests of the child focuses on creating an environment for the child’s opinions, views and valuations to be expressed alongside those of parents and healthcare professionals in mutual negotiations with a reinforcement of communication skills among healthcare professionals. Developing the six principles further, in accordance with the various guidelines for paediatric clinical practice, may (i) direct courses of action; (ii) help set priorities; and (iii) provide new insights to healthcare professionals on areas to focus on when optimising the best interests of the child in care situations. Reflections and discussions on how to protect the best interests of the child may help healthcare professionals incorporate the UNCRC into daily clinical practice.

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CONFLICT OF INTEREST

The authors do not have any conflicts of interest to declare.

AUTHOR CONTRIBUTIONS

The first author participated in the study design, ethical approval application, data collection, analysis and drafting of the manuscript. The second author participated in data analysis, reviewed the manuscript, as well as co-supervision. The third, and fourth authors participated in study design, data analysis and reviewed the manuscript. The last author participated in the study design, ethical approval application, data collection, data analysis, reviewed the manuscript and supervision. All authors read and approved the final manuscript.

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