How children's rights are constructed in family-centred care: A review of the literature
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What is This?
How children’s rights are constructed in family-centred care: A review of the literature

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Abstract
It appears that the acceptance of children’s rights within the acute care setting is treated as a given but such a given requires a more systematic analysis. This has been undertaken here in the form of a review of the literature. The purpose of the review is to explore how children’s rights, defined by the United Nations Convention on the Rights of the Child (UNCRC) are recognized in family-centred care in the acute care paediatric setting as reported in the literature. Reports that were available from 1989 to 2010 were reviewed. Children’s rights are not mentioned frequently in the literature of interest to children’s nurses. What is revealed are the ethical tensions in the challenge to act at all times in children’s best interests (in the spirit of Article 3) while giving due weight to their views (in the spirit of Article 12) (OHCHR, 1989). The continuing failure to address these tensions undermines the spirit and practice of family-centred care.

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Keywords

Introduction
The concept of family participation in care has been espoused by paediatric nurses for over 50 years. The process is underpinned by an assumption that there is a balance of power, and children and families are provided with opportunities to negotiate (Smith et al., 2002; Shields et al., 2006; Corlett and Twycross, 2006). The child is central to the concept of family-centred care, being the person on which care and treatment are focused. However, children continue to face challenges in being meaningfully and actively involved in decisions about their health care, particularly in hospital settings (Bricher, 1999; Coyne, 2006a, 2006b; 2008; Coyne et al., 2006).

This paper arose during a research project about how nurses negotiated the involvement of children and their families in the delivery of care and decision-making about treatment (Lewis et al., 2007; Hooke et al., 2008), and as we attempted to make sense of the family-centred care literature from the perspective of the children, and children’s rights. We gained the impression from the children in our study, that they were passive, in other words, the children allowed procedures to be done to them and that they were dependent, mainly on their parents. The children that we talked to relied on their parents to talk to staff, to obtain information and to be with them in hospital (Lewis et al., 2007). The vulnerability of the children has led us to examine how the wealth of family-centred care literature published in the last two decades addresses the human rights of children in an acute care hospital setting. This discussion is framed with reference to the guidelines of the United Nations Convention on the Rights of the Child (hereafter called the Convention) (OHCHR, 1989) as it is these guidelines that encapsulate the universal rights of children. We were particularly interested in how the family-centred care literature described how nurses met the rights of hospitalized children. This paper presents a review of literature since 1989 (when the Convention was adopted) that examines children’s rights as expressed in family-centred care in the acute care hospital paediatric setting.

Background
The Convention is a universally accepted human rights document. While the Convention does not impose legal obligations on countries, it does provide a framework for accountability to make things happen (Hall, 2005). Historically children have not been granted full personhood; rather they have been understood to be the property of their father (Spencer, 2000; Shields et al., 2003). Over time, children have been recognized as needing special care and protection (Lowden, 2002). Traditionally many of the Bills and Charters concerning children’s rights have been in response to violations, often horrific, of specific groups of children.

Children are not just subject to protection but are holders of civil and political rights (de Boer-Buquicchio, 2008). The move to grant children greater rights more recently has been formally expressed in the Convention. The importance of the Convention is that it recognizes that children are the subject of rights and that those rights impose obligations on adults to ensure their execution and to address the inter-relation between the rights (Lansdown,
There are positive rights, such as the right to health care and negative rights, for example not to be tortured (Hall, 2005). Overall, the Convention tends more towards protecting children from mistreatment than promoting their empowerment (Baxter et al., 1998) and relies on parental good will, emphasizing the exploration of cultural values before determining if children’s rights have been violated (Gabbai et al., 1999).

The most relevant Articles within the Convention with respect to this paper are Articles 3, 12 and 24. Article 3 relates to the best interests of the child, taking into account the rights and duties of parents or legal guardians. This article also refers to standards particularly in relation to the safety and supervision of children and suitable staffing within health care. Article 12 is concerned with the child’s right to express their view freely where the child is capable of forming a viewpoint and holds that this will be given due consideration in all matters that relate to that child. Health care is the subject of Article 24 of the Convention. This right covers access to the highest possible standard of care and the right to knowledge and education (for a child and their carers) relating to health care and safety.

The overriding principle in relation to hospitalized children is Article 3, in other words, the best interests principle. The welfare of the child is paramount, however the depth and meaning of that concept is not fully clarified in professional guidelines (Baxter et al., 1998). Too often best interests means what adults think best, but, over time, these best interests can change, for example excluding parents during hospitalization is no longer acceptable (Lansdown, 2000). Accordingly, the best interests principle cannot be used to ‘trump’ all other rights. Family-centred care (FCC) would seem to apply this principle of acting in the child’s best interests as it is broadly assumed that the child’s family has their best interests at heart (Ross, 1997).

There has been considerable research and academic endeavour to validate the necessity for family-centred health care delivery. While FCC is evident within the rhetoric of paediatric care, achieving this in reality continues to be a challenge (Casey, 1988; Ahmann, 1994; Coyne, 1995, 1996; Keatinge and Gilmore, 1996; Callery, 1997; Hutchfield, 1999; Newton, 2000). A number of barriers to the practice of FCC are highlighted in the literature (Callery and Smith, 1991; Casey, 1995; Knight, 1995; Johnson and Lindshau, 1996). Whilst nurses understand and espouse a philosophy of FCC they don’t always seem to achieve the principles in practice (Petersen et al., 2004). If nurses and other health professionals believe that children’s rights are met by the practice of FCC, then the fact that FCC is not always a reality in paediatric practice may led to children’s rights being overlooked.

**Methods**

We used a systematic approach to searching and assessing the available literature, inspired by the work of several authors, to produce a qualitative synthesis of the literature (Whitmore and Knafl, 2005; Horton et al., 2007; Akerjordet and Severinson, 2008).

The aim of the review is to examine how children’s rights are represented within the FCC literature and discuss implications for nursing practice. The question asked is: how have children’s rights become evident within the literature on FCC, since the Convention?

**Search history and inclusion criteria**

Literature searches were conducted in CINAHL (Cumulative Index of Nursing and Allied Health Literature), MEDLINE and EMBASE. When combined keyword searches of children’s rights OR
United Nations Convention on the Rights of the Child WITH family-centred care were carried out, only one paper was identified. In order to increase the opportunity to identify appropriate literature the search terms were widened. The following search terms were used: United Nations Convention on the Rights of the Child (keyword); Children’s rights (keyword); Patient rights; Family centred care (subject heading); Family centred care (keyword); Consumer participation (subject heading); Consumer participation (keyword); Parent–child relations (subject heading); Family involvement (subject heading); Family involvement (keyword); Parent participation (keyword); Child participation (keyword); Adolescent participation (keyword); Child, hospitalized (subject heading); Child, hospitalized (keyword); Pediatric care (subject heading); Hospitalized child (keyword); Pediatric care (keyword). Combined searches were conducted in order to find relevant papers. Hand searches of identified papers were carried out and information from a Google search of relevant websites such as the European Association for Children in Hospital, Children’s Hospitals Australasia and the Association for the Well-being of Children in Healthcare was considered.

Papers were considered for the review if they met the following criteria: the subjects or informants of the reports were children, health professionals, parents or parent figures of children; there was specific focus on children’s rights; there was specific focus on the acute care in-patient pediatric setting; they were published between 1989 and 2010; and they were written in English. The search was restricted to English-language reports for practical reasons. Any type of research paper, literature review or report was considered, including papers reporting experience of children and/or family members. Personal opinion papers from health professionals, letters, editorials and conference proceedings were excluded from the review. To reduce the risk of bias the inclusion and exclusion criteria were determined before the literature search and sustained throughout the collection of the papers. Two of the authors (MK and SJ) conducted literature searches, screened papers for inclusion and extracted the themes reported.

Results

The results of the literature search can be seen in Figure 1.

There were 21 papers that met the inclusion criteria (Table 1). Hand searching papers did not result in any further papers beyond those identified from the databases searched. The majority of included papers (76%) emanated from the UK and Europe. It is perhaps not surprising that there is relatively little literature on this topic from the US which has not ratified the Convention. The US literature deals predominantly with child maturity and informed consent in terms of the law (Oberman, 1996; Hickey, 2007), which is outside the scope of this review. In addition to those papers meeting the inclusion criteria, six general papers that relate to FCC but which are not specifically about children’s rights are included to inform discussion of one of the themes.

There were four themes that emerged from the FCC literature in relation to children’s rights. These were: themes regarding children’s participation in decision-making about their health care; the voice of children; viewing family-centred care through the lens of children’s rights and the place of parents; and teasing out tensions in family-centred care. We found that the themes were connected and provided areas of overlap. For example, children’s participation in decision-making about their health care was strongly linked to the theme of children having a voice. Although we found some overlap in themes, each of the themes identified from the included papers is discussed separately below.
Children’s participation in decision-making about their health care

The value of children being able to actively participate in care is undeniable, with physical and psychological benefits as the child’s sense of self-determination increases. Participation increases children’s cooperation with their care (Coyne, 2006a) and they gain knowledge, skills and responsibility in their own care. There is little evidence, however, that children are actively involved in decision-making (Runeson et al., 2002; Coyne, 2008). Although nurses encourage children’s participation, it is at the implementation phase rather than the decision-making one (Bricher, 2006b).
### Table 1. Included papers

<table>
<thead>
<tr>
<th>Author/s</th>
<th>Year</th>
<th>Focus of paper</th>
<th>Source</th>
<th>Themes addressed*</th>
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<tr>
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<td>1</td>
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<tr>
<td>Ross LF</td>
<td>1997</td>
<td>Discussion paper</td>
<td>US</td>
<td>Yes</td>
</tr>
<tr>
<td>Doyle KA and Maslin-Prothero S</td>
<td>1999</td>
<td>Discussion paper</td>
<td>UK</td>
<td>Y</td>
</tr>
<tr>
<td>Rushforth H</td>
<td>1999</td>
<td>Literature review</td>
<td>UK</td>
<td>Y</td>
</tr>
<tr>
<td>Bricher G</td>
<td>2000</td>
<td>Research paper – interviews with</td>
<td>Australia</td>
<td>Y</td>
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<td></td>
<td></td>
<td>pediatric nurses</td>
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<tr>
<td>Glasper A and Powell C</td>
<td>2000</td>
<td>Review of evidence base for</td>
<td>UK</td>
<td>No</td>
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<td></td>
<td></td>
<td>parental presence in anaesthetic</td>
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<td>room</td>
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<td>Noyes J</td>
<td>2000a</td>
<td>Research paper – interviews with</td>
<td>UK</td>
<td>Y</td>
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<td>ventilator dependent young people</td>
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<tr>
<td>Noyes J</td>
<td>2000b</td>
<td>Research paper – interviews with</td>
<td>UK</td>
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<td></td>
<td></td>
<td>ventilator dependent young people</td>
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<tr>
<td>Charles-Edwards I</td>
<td>2001</td>
<td>Discussion paper</td>
<td>UK</td>
<td>Y</td>
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<tr>
<td>Flatman D</td>
<td>2002</td>
<td>Discussion paper</td>
<td>UK</td>
<td>Y</td>
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<tr>
<td>Runeson I et al.</td>
<td>2002</td>
<td>Research paper – observation of</td>
<td>Sweden</td>
<td>Y</td>
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<td></td>
<td></td>
<td>hospitalized children</td>
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<tr>
<td>Hallstrom I and Elander G</td>
<td>2004</td>
<td>Research paper – observation of</td>
<td>Sweden</td>
<td>Y</td>
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<td></td>
<td></td>
<td>hospitalized children</td>
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<td>Alderson P et al.</td>
<td>2006</td>
<td>Research paper – semi-</td>
<td>UK</td>
<td>Y</td>
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<td></td>
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<td>structured interviews</td>
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<td>Coyne I</td>
<td>2006a</td>
<td>Research paper – interviews with</td>
<td>UK</td>
<td>Y</td>
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<td></td>
<td></td>
<td>children, parents and nurses</td>
<td></td>
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<tr>
<td>Taylor B</td>
<td>2006</td>
<td>Experience of child and parent</td>
<td>UK</td>
<td>Y</td>
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<tr>
<td>Le Francois B</td>
<td>2007</td>
<td>Research paper – observation in</td>
<td>Canada</td>
<td>L</td>
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<td></td>
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<td>adolescent mental health unit</td>
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<tr>
<td>Baston J</td>
<td>2008</td>
<td>Literature review – children in</td>
<td>UK</td>
<td>Y</td>
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<td></td>
<td></td>
<td>health care decisions</td>
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*Themes addressed: 1 = Yes, 2 = Limited, 3 = Y, 4 = N.
<table>
<thead>
<tr>
<th>Author/s</th>
<th>Year</th>
<th>Focus of paper</th>
<th>Source</th>
<th>Themes addressed*</th>
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<tbody>
<tr>
<td>Coyne I</td>
<td>2008</td>
<td>Literature review</td>
<td>UK</td>
<td>Y Y Y Y</td>
</tr>
<tr>
<td>Migone M et al.</td>
<td>2008</td>
<td>Research paper – survey of staff, children and parents re EACH charter</td>
<td>Ireland</td>
<td>Y Y Y N</td>
</tr>
<tr>
<td>Watson P</td>
<td>2008</td>
<td>Discussion paper</td>
<td>New Zealand</td>
<td>Y Y Y L</td>
</tr>
<tr>
<td>Pelander T et al.</td>
<td>2009</td>
<td>Research paper – testing validity of the CCQH instrument</td>
<td>Finland</td>
<td>Y Y L L</td>
</tr>
<tr>
<td>Moore L and Kirk S</td>
<td>2010</td>
<td>Literature review about participation of children and young people in health care decisions</td>
<td>UK</td>
<td>Y Y Y Y</td>
</tr>
</tbody>
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Note: * 1 = children’s participation in decision-making about their health care; 2 = the voice of children; 3 = viewing family-centred care through the lens of children’s rights and the place of parents; 4 = teasing out tensions in family-centred care.
Choices that are offered to children for decision-making often have little relevance to their health care, in other words, they are ‘soft’ choices, for example the choice of food to eat while in hospital or play activities to engage in (Doyle and Maslin-Prothero, 1999; Moore and Kirk, 2010).

Children’s capacity to consent, and hence their capacity to be involved in decision-making about their care and treatment, is complex and inconsistent. Informed consent is not a static concept and many factors make it confusing and complex. However, judgements about children’s competence to consent are variable (Ross, 1997; Rushforth, 1999; Charles-Edwards 2001; Flatman, 2002). It seems that children are deemed competent if they agree with health professionals but incompetent if they refuse treatment (Bricher, 2000; Flatman, 2002). Indeed, although in some circumstances children are considered competent to consent to treatment, refusal of treatment is not an option (Bricher, 2000).

Traditional determinants of competence include chronological age and child development theories. Nurses demonstrate wide expectations of the minimum age at which children can participate in their care, from between 3 to 10 years (Bricher, 2000). However, a number of authors point out the difficulty of basing competence on age, particularly for children with chronic conditions. There is evidence that children as young as 4 years are capable of accurately recalling information and being involved in decision-making relating to their health care (Rushforth, 1999; Flatman, 2002; Alderson et al., 2006; Taylor, 2006; Watson, 2008). Moreover, competence is not fixed or measurable and varies with context. It has been suggested that competence of the child should be assumed and the test should be to disprove it (Rushforth, 1999; Baston, 2008). The onus is then on the adult to justify their actions.

Despite this, adults’ knowledge of children’s decision-making capacity is limited and often results in children’s potential to participate being underestimated (Doyle and Maslin-Prothero, 1999; Rushforth, 1999; Alderson et al., 2006). These views serve to ensure that children are not provided with opportunities to participate in their care and decision-making in relation to their health care. In terms of competence, there are two conflicting points of view. The conservatives or child protectionists seek to guard children, arguing that children are vulnerable and powerless and in need of protection and that adults ‘know best’. The liberal position or the child liberationists, on the other hand, argue that such treatment increases children’s helplessness (Ross, 1997; Rushforth, 1999). A third approach taken to competence is that of the pragmatists. This group strikes a balance between the liberationists and protectionists in believing that children need protection but should be involved in decision-making to the extent that is feasible for the individual child (Rushforth, 1999). Given these conflicting views, it is not surprising, then, that there is confusion about the best approach to take towards involving children in their health care and that the child’s voice often goes unheard.

The voice of children

The literature revealed that obtaining children’s views is problematic; specifically the channels and mechanisms are often inadequate. Coyne noted increasing direct consultation with children about matters that affect them based upon national, international and health policy directives, although implementation is patchy (Coyne, 2006a). Some work has been done to actively seek children’s perceptions of the care they have received. In 2009, Pelander and colleagues reported the development of an instrument designed specifically to elicit children’s views on the quality of nursing care. The authors suggest that the instrument provides an avenue for children to assess the
quality of their nursing care, and that their assessment can be used to identify areas for development to ensure a truly child-centred approach to care delivery (Pelander et al., 2009).

In the acute care setting, even though the child is the key object of attention and activity, children appear to have little control over what happens to them or any voice in their care (Rushforth, 1999; Bricher, 2000; Runeson et al., 2002). For instance, research undertaken with ventilator-dependent children reported that they are treated in a patronizing way, as if they are a burden, and their rights are not respected (Noyes, 2000a, 2000b). Children have reported that they should be informed and consulted about their care (Hallstrom and Elander, 2004; Moore and Kirk, 2010), but their views are often ignored by adults, considered inappropriate or may not even be sought, instead relying on parents’ views (Flatman, 2002; Coyne, 2006a; LeFrancois, 2007; Coyne, 2008; Migone et al., 2008; Watson, 2008), and children describe a lack of autonomy (Noyes, 2000a, 2000b). This raises the question of whether health professionals caring for children believe that the child’s voice is heard through the provision of family-centred care.

Viewing family-centred care through the lens of children’s rights and the place of parents

It is generally accepted that families have the best interests of their children at heart (Ross, 1997) and that it is within the family unit that children’s rights are maintained. Family-centred care may be considered an appropriate mechanism to promote children’s rights; see, for example, the definition of FCC as: ‘a process in which the family and child are professionally supported in their involvement, participation and partnership in care based on an assumption of balanced power and the opportunity to negotiate’ (Smith et al., 2002: 81). A number of authors considered that FCC can address children’s rights since it deals with their needs (Newton, 2000; Corlett and Twycross, 2006; Shields et al., 2006; Lewis et al., 2007). There is evidence that hospitalized children nursed in a family-centred environment, for example, exhibit decreased crying and restlessness, and less medication has been documented (AAP, 2003). Alternatively, the failure to practise FCC could result effectively in a denial of children’s rights. An example of this was given by Glasper and Powell (2000) in their discussion of parents’ ability to accompany their children to the anaesthetic room. They point out that, despite a wealth of evidence highlighting the benefit to the child of having parents stay with the child in hospital, there is still conflicting views from health professionals in relation to anaesthetic rooms (Glasper and Powell, 2000).

As we unpacked the central ideas surrounding FCC and children’s rights, contradictory and competing elements became apparent. It became clear that adherence to FCC per se, cannot be assumed to promote children’s rights. We identified some areas of tension within the literature concerning family-centred care.

Teasing out tensions in family-centred care

There is a tension in resolving the individual needs of children, parents and nurses. The principles of FCC are said to take account of the preferences of family members in providing care, but do not specify what to do when the parties cannot resolve their differences. Doyle and Maslin-Prothero (1999) highlight that the influence of illness on children, their regression and limited number of coping mechanisms reduce their capacity for autonomy. None of these concerns however, prevent adults from taking into account children’s views. Such tension presents a challenge to
nurses to find a balance between working within a family-centred model of care delivery and ensuring that the rights of the child are met. This is particularly pertinent when there is conflict between the child’s wishes and those of the family and the issue arises of whose views should be acted upon. Disagreements are partly a question of whose priorities are addressed or even acknowledged (Bricher, 2000). Children’s protests are reduced to childish complaints rather than reasonable objections, even talked of as if they are not significant, and parents’ wishes are given precedence (Runeson et al., 2002; Hallstrom and Elander, 2004). The FCC literature indicates that the presence of parents ameliorates many of the adverse effects of hospitalization and there are a number of compelling legal and ethical reasons for the autonomy of parental decision-making. Parents are not surrogate decision-makers because children are incompetent but because they have a right and a responsibility to be included in consultations as proxy decision-makers (Ross, 1997); particularly as health professionals only meet children’s transient health care needs. There are pragmatic reasons to permit parents to over-ride children’s autonomy, such as the difficulty of assessing decision-making capacity (Ross, 1997). Although the American Academy of Paediatrics recommends giving children a greater voice in decision-making, Ross (1997) thinks that parents should have final say when there is disagreement. Conflict between children’s wishes and those of their parents presents a considerable dilemma to nurses and other health professionals in balancing the rights of children with the rights of parents as legal decision-makers.

A further area of tension is that parents are the key players in FCC models at the expense of children. Indeed, reports of parents’ experience are more expansive than those of children (Coyne, 2006a). When the emphasis moves to parents as consumers of paediatric health care, children are at risk of being objectified or even marginalized.

Discussion

Active promotion of children’s’ rights is more likely to occur if health professionals believe in the importance of those rights (Baston, 2008). However, the ways in which nurses care for children and their families is influenced by the way society understands children. Society defines childhood and, historically, children’s nurses have been part of questionable ethical activities, such as separating children from their parents (Bragadottir, 2000). The beliefs of nurses about children vary and this has led to inconsistencies in children’s participation in decisions about their care (Coyne, 2006a). The outcome of this construction of children is that children are treated as helpless, even impaired. The implications are that children’s opinions are ignored by adults and their situation is not fully explained to them. Although the literature highlights that FCC can be a way of addressing children’s rights, in reality if health professionals are not practising FCC, then children’s needs rather than their rights are what receive attention (Lowes, 1996). The focus on parents often described in the literature may result in the recognition of children’s rights being inhibited (Lowes, 1996), a possibility which often is not a visible factor in decision-making in relation to a child and their family. These assumptions promote a safety net mentality that can run counter to child-centred views and active participation in health care decisions (Lansdown, 2000).

Participation of children in their health care

Children’s nurses are expected to encourage participation in decision-making (Coyne, 2006a) because they have the opportunity to explain to children the implications of their decisions
and feed their curiosity (Peace, 1994; Orr, 1999). However, there is tension apparent when nurses think they know what children want rather than establishing what children actually want (Bricher, 2000). Nurses often state that they are advocates for the children and families in their care (Drake, 2001). However, rather than being the advocate, perhaps the question nurses should be asking themselves is how they can enable the child’s voice to be heard? According to Charles-Edwards (2001), the child’s voice can be heard when they are appropriately informed. Having a child refuse care or treatment is particularly confronting for nurses who may not recognise that children have their own values. Consultation is important but becomes insulting and hypocritical if there are no commitments to respond to what children say (Brook, 2005; Hall, 2005; Waterston, 2005). To respect only those decisions with which we agree does not show respect for children’s rights and it is clear that children cannot refuse treatment in the way an adult can (Bricher, 2000; Spencer, 2000), although they frequently protest at the procedures they are required to endure (Drake, 2001). In situations of reluctance and refusal, adults, both health professionals and parents justify their actions to override the children’s wishes by appealing to Article 3. This means ensuring that children in need of interventions receive them (Middleton, 1997) because the duty of the professional is to consider the child’s best interests in all aspects of care delivery (Alderson et al., 2006). Such a consideration however, should give due weight to the children’s view (Article 12). Researchers continue to elicit the views of children in terms of their hospitalization experiences (Carney et al., 2003; Salter and Stallard, 2004; Clift et al., 2007; Moules, 2009) but it is not obvious in the FCC literature whether these accounts are truly listened to in the everyday reality of caring for children in an acute-care setting and whether nurses and other health professionals pay attention to such accounts.

**Translating the Convention into practice**

Most of the literature that employs the Convention does not directly address professional practice, nor is it written by or for professionals caring for children. Translating the Convention into practice is difficult and compromised by competing interests where children are beholden to the caprice of adults. Brook (2005) and Kurz et al. (2006) suggest ways in which nurses and paediatricians can incorporate children’s rights into their practice. These include actively listening to children, providing age-appropriate information, talking to the child as well as the parents, encouraging questions, encouraging parents to involve children, providing space and opportunity for children to process information and acting on children’s views (Brook, 2005; Kurz et al., 2006). Children need information to be provided in age-appropriate ways, and given time to process the information and to ask questions in order to develop knowledge (Alderson and Montgomery, 1996; Orr, 1999; Lowden, 2002; Coyne, 2006b; Wright, 2009). This places an onus on nurses and other health professionals to ensure that suitable information is available and that the child has time to process it.

A number of initiatives have been developed to incorporate the Convention into hospital-based care of children. One such programme is the Child Friendly Health Initiative (CFHI) (Southall et al., 2000; Nicholson and Clarke, 2007). The CFHI is an international project designed to advance children’s rights in the acute care setting. The importance of the CFHI is that it explicitly incorporates the Convention’s principles into practice by proposing standards for care that are based on the Convention. Indeed, the CFHI has taken the applicable sections of the Convention and employed them to direct hospital policy (Southall et al., 2000).
The European Association for Children in Hospital (EACH) has established a charter of children’s rights encompassing 10 articles for children before, during or after a stay in hospital (EACH, 1988). The charter, which directly aligns with the Convention, highlights the importance of age-appropriate information, the presence of a parent with the child in hospital and the importance of involving children and their parents in health care decision-making. Migone and colleagues (2008) conducted a survey with staff, children and parents to establish whether the EACH charter was actually being complied with in the hospital setting. Their results indicated that, while the majority of children and parents liked the relationship they had with staff, the facilities available in hospital fell short of expectations, and children’s voices were neither sought nor heard by clinicians (Migone et al., 2008). In 2010, Children’s Hospitals Australasia launched a Charter on the Rights of Children and Young People in Healthcare Services in Australia. This charter outlines 11 rights and is available in children’s and young people’s versions (Children’s Hospitals Australasia (CHA) and the Association for the Well-being of Children in Healthcare (AWCH), 2010).

These initiatives indicate that the means exist for health professionals to embed children’s rights within their practice. However, there is little evidence from the literature that these are applied consistently. It appears, from our examination of the literature that the philosophy of FCC, espoused by paediatric health professionals, does not incorporate children’s rights in an explicit way and this is something that needs to be addressed by all those caring for children and young people in a health care setting. Health care professionals need not only to be aware of charters of rights that exist, but to act on them consciously and consistently. The Convention on the other hand, does not take into account the social context of FCC within which children, parents and professionals interact. Family-centred care doesn’t just happen, it is complex, espoused but rarely acted upon, requires reflection, teamwork, learning and change (Wilson et al., 2005; Wilson and Walsh, 2008). The issue is how those caring for children can take into account the individual differences in children and their families and the variability in families in their ability to manage. We believe that we are not getting FCC right all the time but we should not abandon the concept. Health care professionals need to work on ensuring that FCC is practised to its full extent and that this actively incorporates meeting the rights of the child. This will enable staff to deliver care that is flexible and inclusive of children’s views as well as those of the adults involved. The central matter in flexible care is communication and assisting children and parents to regain control. Recognising children’s rights, therefore, means modelling belief in and respect for children’s autonomy. Health professionals need to consider the practical ways in which recognition of children’s rights and the Convention can become part of their everyday practice.

**Conclusion**

Constraints to the recognition of children’s rights in the acute care setting have been suggested by a number of authors (Booth, 1994; Fulton, 1996; Bricher, 2000). While there is increasing recognition of children’s rights in national, international and health policy directives, this must be accomplished within the reality of interaction between children, parents and health care professionals. The challenge is to integrate children’s rights as they are expressed in the Convention more fully into the practice of family-centred care. The failure to explicitly address children’s rights renders FCC unable to meet its purpose. We consider that health care professionals need to work out ways to integrate a children’s rights paradigm explicitly into the care of children and their families in hospital. However, we wish to emphasize the importance of acknowledging the dilemma of acting in the child’s best interests while still acting on the child’s wishes. This dilemma is acted out within
the contextual features and the different values and beliefs present in any care delivery arena and must be taken into account as they evolve around our understanding of children.

References


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