PXJ

Patient Experience Journal

Volume 5
Issue 2 *Patient & Family Experience in Children's Hospitals and Pediatric Care*

Article 7

2018

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Recommended Citation

Didier, Amélia; Gachoud, David; von Niederhäusern, Gabriela; Benaroyo, Lazare; and Zumstein-Shaha, Maya (2018) "Caring moments within an interprofessional healthcare team: Children and adolescent perspectives," *Patient Experience Journal*: Vol. 5 : Iss. 2 , Article 7.
Available at: http://pxjournal.org/journal/vol5/iss2/7

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Cover Page Footnote
The authors would like to thank the co-investigators of the parent study, i.e. Professor Dr Brigitte Liebig and Professor Dr med. Jean-Pierre Pfammatter, as well as the scientific collaborator, Mrs Vanessa Alvarado, for their support.

This research is available in Patient Experience Journal: http://pxjournal.org/journal/vol5/iss2/7

PXJ
Patient Experience Journal
Volume 5, Issue 2 – 2018, pp. 23-31

Research

Caring moments within an interprofessional healthcare team: Children and adolescent perspectives

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Abstract
Patients are now recognized as key partners to improve healthcare outcomes. Some organisations such as the WHO or the Canadian Interprofessional Health Collaborative (CIHC) encourage considering patients as partners in the interprofessional healthcare team. However, limited knowledge exists on patients' perspective of interprofessional collaboration (IPC) and of their role in the collaborative process, particularly in pediatric settings. The experiences and perspectives of patients regarding IPC have to be considered in order to fully understand the concept of IPC and integrate it into practice. This qualitative study aimed at gaining a better understanding of the perspective of children of IPC, how it affects their experiences of care and how they perceive their own role within the interprofessional team. Semi-structured interviews were used in the pediatric service of a Swiss university hospital, with ten children and adolescents aged between 11-17 years. The participants described the interactions they observed between nurses and physicians and provided insights into how they perceived the quality of that relationship. A respectful relationship between nurses and physicians may have improved the experience of a caring environment. The participants did not perceive their role to be pivotal into the interprofessional relationship. The findings of this study indicate that the interactions between healthcare professionals have an influence on the perspectives and experiences of the participants of their hospitalisation and of IPC. However, integrating children and adolescents into collaborative process will need a change of paradigm and beliefs regarding IPC.

Keywords
Perceptions, perspectives, relationship, interaction, pediatric, interprofessional collaboration

Introduction

Interprofessional collaboration and children's perspectives in pediatric settings

Key strategies to improving quality of care and safety consist in optimizing interprofessional team-training, and considering patients as partners.[1–3] The Canadian Interprofessional Health Collaborative (CIHC) defines interprofessional collaboration (IPC) as a process that involves patients, their families and the whole community to enhance healthcare outcomes.[4] Quality of care and patient safety are of high importance since the Institute of Medicine revealed the dangers of healthcare systems with 48,000-98,000 patient deaths per year.[5] The CIHC definition maintains two aspects for care optimization: interprofessional collaboration and the involvement of patients, families and the community as new partners in the process of interprofessional collaboration.[4] In pediatric settings, IPC is associated with improved patient information, reduced medication errors upon discharge,[6] fewer adverse events after discharge,[7] reduced length of stay, and improved adherence to best practices in pediatric settings.[6]

CIHC contends that collaborating with patients, families and communities as partners will lead to better outcomes.[4] However, IPC, even limited to professionals, raises complex issues of power-sharing, interdependence, educational or cultural background.[8,9] Furthermore, the relevance of the patient partnership is disputed. Some authors argue that patient partnership is academic rhetoric rather than a reality.[10] In a recent study, conducted in adult healthcare settings, a dissonance was described between health professionals' practice and their discourse.[11] Although health professionals welcome patients as team members and partners, no real opportunities are provided

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to endorse this role.[11] Nevertheless, other authors report that integrating the patients' perspective into pediatric settings will improve quality of care.[12,13] Therefore, it is imperative to explore the children's and adolescents' perspective. It will then be possible to identify the aspects of IPC important to them, for a wise integration of the patients into IPC. A few authors have explored the children's perspective of relationships between healthcare professionals,[14,15] or of collaborative practices such as family-centered rounds.[16] Implementing IPC in practice is complex in pediatric settings due to a lack of a common understanding or clearly defined roles as well as insufficient way of sharing information between the professionals.[17,18] Children and adolescents were found to identify power relationships between healthcare professionals.[14] Due to interactions with a large number of health professionals or due to limited understanding of discussions held at the bedside, children and adolescents were intimidated.[16,19] Participation in IPC might as well be restrained due to the participants' preference not to be involved in decision-making.[20] This begs the question as to what extent a person-centered approach to IPC, as promoted by CIHC's definition, is practicable in pediatric settings. Understanding the patient's point of view is perceived to "increase the professionals' awareness that their actions have real consequences".[21,p.527] Risjord, in the same vein as other authors,[22] argues that a concept can only be fully understood if patients' feelings and thoughts are considered and integrated.[23] Therefore, exploring the children's perspective is important to provide health professionals with an external view on IPC. Thus, social, professional or personal barriers still impeding IPC may be overcome.

Only limited knowledge of the children's perspectives of IPC and its relevance in pediatric settings exists.[14-18] Most studies have been conducted in adult healthcare settings.[11,24,25] The aim of our study was to explore the children's experience of being cared for by an interprofessional team, and to elicit their understanding and expectations regarding interprofessional relationships between nurses and physicians. As a result, health professionals' awareness of importance of IPC will be enhanced. It will be possible to adapt the interprofessional relationships accordingly. A second aim was to elicit children's and adolescents' views on their perceived role in the interprofessional care team. The research questions were as follows: (1) What are children's and adolescents' experiences within an interprofessional healthcare team? (2) What does IPC mean for children and adolescents? (3) What are the influences of IPC on their care, from the children's and adolescents' perspective? (4) What are children's and adolescent's perceptions about their own role in the interprofessional collaborative process?

Methods

This qualitative study involving semi-structured interviews with children and adolescents was conducted between June 2016 and April 2017.

Setting and participants

Data was collected in a pediatric university department in Switzerland with a capacity of 12 beds. The patient population included children and adolescents with neurological, endocrinal, psychosomatic and cardiologic diseases. The age of inpatients varied from 3 to 17 years. Some children and adolescents had to stay in hospital for several weeks (see Table 1). Parents could visit at any time. Parents were free to attend medical ward rounds to clarify any doubts and plan the care process. However, the encounter of health professionals and parents mostly happened in the absence of the pediatric patients. The healthcare team consisted of medical specialists (pediatricians, cardiologists, neurologists, endocrinologists, rheumatologists, psychiatrists…), nurses (registered nurses, advanced practice nurses, nursing experts, i.e. in cardiology, diabetes and nephrology, assistant nurses and nursing auxiliaries), social workers (educators and counsellors), psychologists, therapists (speech and language therapists, occupational therapists, nutrition and diet therapists), chaplains, pedagogues (educators and handicraft teachers), hospital clowns, and volunteers.

For the participants the following inclusion criteria were applied: children, adolescents admitted to the pediatric university department, without cognitive or language impairments, and in a stable health condition. Data

Table 1. Demographics and clinical data of 10 participants

Demographics and clinical data	Boys	Girls
Gender	2	8
Mean age	13	14
Diagnosis		
Psychosomatic disease	0	5
Cardiologic disease	1	0
Metabolic disease	0	3
Other	1	0
Hospitalization for more than a week	2	5
Only 1 interview conducted	2	5
2 interviews conducted	0	3

collection was carried out until the ideas shared by the participants became recurrent. The final sample consisted of 8 girls and 2 boys aged between 11 and 17 years (Table 1).

The pediatric participants signed a consent form, as did the parents or legal representatives, as required by the directives resulting from the Swiss Federal Act on Research involving Human Beings (Art. 21-23).[26]

Ethical considerations
The protocol of this study had been submitted to the local cantonal ethics committee and to the institutional pediatric ethics committee. Both ethics committees allowed the research team to proceed to data collection.
The directives resulting from the Swiss Federal Act on Research involving Human Beings (Art. 21-23) were followed.[26] A close partnership with the head nurse, who was fully aware of the overall condition of the children and adolescents, the daily life and organization of the ward, and the schedule of activities, made it possible to approach only stable participants who were not in acute phases of illness, thus sparing them any kind of pressure or additional stress.

Data collection and analysis
The head nurse orally informed children and adolescents selected, based on the inclusion criteria about the study before handing over the written information sheet and the consent form. Then, the researcher contacted the children, adolescents and their parents or legal representatives to answer pending questions. After consent was obtained from the children and adolescents, their parents or legal representatives respectively, an interview was scheduled during the hospital stay. The interviews were focused on the children's and adolescents' experiences. A second interview was scheduled with some participants who wished to reflect in more detail on various aspects of the hospitalization or of IPC. Two girls were hospitalized in their early childhood, hence had few memories of their last hospitalization, and were hospitalized less than one week as the interview took place. A second interview was organized with these girls. One other girl felt very tired during the interview and agreed to organize a second interview.

Parents or legal representatives of children and adolescents were free to stay during the interviews; only one parent decided to stay.

The semi-structured interview was based on one open question on hospitalization (Table 2) and some specific questions on IPC. With the open question on hospitalization, the participants' experience was explored. Further insight of the children's and adolescents' perspective of IPC was obtained with specific questions.

The interviews were all audio-recorded and transcribed verbatim. Two researchers analyzed the data, discussed its interpretation, categorized it, and translated the quotations from German into English. The research team organized a workshop with clinical experts for member checking, within the participating hospital. An academic member check was done when this paper was being prepared, through validation by two clinical experts: one nurse and one physician. A general qualitative data analysis process was applied; this included coding, and condensing and reducing the codes into themes.[27]

Results

The sample consisted of 10 children and adolescents, aged between 11 and 17 years. At the time of the interviews, the participants had been in hospital care for between one and three weeks. The participants had chronic and stable conditions. In total, one parent decided to be present in one first interview.

The data obtained from the children and adolescents was organized into three main themes: the caring experience, relational aspects of IPC, and the child's perceived role. The caring experience included the codes "receiving kindness" and "having a reassuring presence". The theme relating to the aspects of interprofessional relationships included "information sharing", "hierarchy-respect-complementarity" and "defining collaboration". The child's role was illustrated through "awareness of being a patient". This category included "perceiving one's own role". The names used for the participants are fictitious.

Caring experience

The participants were knowledgeable about their health condition. Although the experience of illness was not enjoyable, every child and adolescent described caring moments overall. These were shaped by the attitude and the presence of the health professionals, more specifically the nurses and physicians.

Receiving kindness
Participants described that the health professionals were attentive to them and their needs. The health professionals demonstrated a caring attitude. In addition, the health professionals were listening constantly, patiently and attentively. These experiences were highly appreciated by the children.

Like I said, everybody was really very kind. They took good care of me, and so on. They always looked after me, they asked if I was in pain, if I needed something. (Tom, 14 years)

Table 2. Examples of questions

Open question	How was your experience during hospitalization?	Depending on the first question: what made your experience positive (if described as positive) or negative (if described as negative). Remark: The participants reported predominantly positive experiences		
Question on IPC	Did you observe the way nurses and physicians work together?	What do you think is important for working together effectively?	Regarding communication, can you tell us more about the way physicians and nurses communicate?	How would you describe collaboration?
Question on the patient's role	Do you think you play a role in the collaboration between nurses and physicians? Regarding to the participants' preference to talk rather about their role in the care process, this question was changed to: How would you describe your role (during the care process)?			

According to the participants' accounts, the caring experience was enhanced by the continuous presence of the health professionals, in particular the continuous presence of the nurses was highlighted.

Having a reassuring presence
The relational competence of nurses and physicians influenced the experience of hospitalization. Health professionals' responsiveness to the children's needs was considered important.

They went outside with me, played games with me, simply talked to me. They were simply just there for me. (Rose, 13 years)

Knowing that health professionals could be reached all the time, influenced the participants' perception of the care. It was also important that nurses would respond to the participants' needs. Two participants referred to the importance of consistent information. They appreciated the fact that the information was regularly shared with them.

Yes, it is important that I know what's going on myself... They explained everything, how I was doing. And they asked how I was feeling, if everything was OK. (Tom, 14 years)

Most of the time, the physician had changed something and had shared it with the nurse… Then the nurse proceeded to explain the current situation to me or what has changed. (Susan, 15 years)

Nurses were the reference person for the children. This was reassuring and allowed the participants to foster a close relationship with the nurses.

I could also see a physician, but the relationship was not as close as with the nurses. (Elena, 15 years)

It is not the same, how physicians and nurses interact with patients. Well, it is not so personal and kind and so on. Well, to some extent yes, but they [physicians, author's note] simply did their job, stated the most important information, and that is it... (Lilian, 16 years)

According to one child, the nurses' role was more suitable for establishing a personal relationship with the patients. The physicians' role, by contrast, was perceived as centered on conducting checks and carrying out examinations. Therefore, the physician–child/adolescent relationship was different in nature.

Well, nurses show an interest in their patients; that's my feeling at least. Well, physicians do, too. But since they check more whether everything is fine and so on, they are more focused on that than on the patient. (Lilian, 16 years)
The participants were asked to share their ideas and perceptions about IPC. This was of interest for understanding the relevance and awareness of IPC. With this question, it was possible to elicit the children's understanding of IPC. The participants mostly observed the interactions between health professionals while information was being shared, which constituted an insight into IPC.

Observing aspects of interprofessional relationships

IPC was not a main concern for the participants. When asked, however, they provided relevant information about the professional relationships between nurses and physicians based on their observations and social representations.

Information-sharing
IPC was observed in terms of relationships between nurses and physicians. The way the nurses and physicians talk to one another and exchange information was important. A friendly and respectful manner from one healthcare professional to the other was considered positive.

Actually, I think they have a very good relationship... yes. Sometimes they laugh a bit and so... Actually, very friendly. (James, 11 years)

I saw that they have some kind of ward round. And that physicians and nurses exchange information… I have a feeling that they work well together. (Rose, 13 years)

Well, they [nurses and physicians, author's note] have a lot to discuss with one another. And also, when the nurse is in charge of me for the whole day, she has to tell the physician everything about me. (Petra, 13 years)

Nurses have to collect information every day. They hand it over to the physicians, and this works really well… Yes, the most important information is passed on and in that way they [the physicians, author's note] are able to make the right decision. (Tom, 14 years)

Hierarchy-respect-complementarity

Children and adolescents saw a clear difference between the role of nurses and physicians. The latter were viewed to be deciders. Therefore, physicians were perceived to occupy a higher hierarchical level. Nonetheless, the hierarchical relationship between nurses and physicians was considered acceptable. It was important to the participants that physicians do not take advantage of their superior role and continue to treat the nurses respectfully.

Well, physicians are on a higher level than nurses…because they have completed their university studies, so to speak. But it is not as if the physician would show off […] I think that the physicians take nurses seriously. (Susan, 15 years)

Only one child described hierarchy in negative terms, pointing out the importance of an effective relationship. This child talked about problems between nurses and physicians, which had been upsetting. For this girl, the superior role of the physicians was questionable. The girl stood up for the nurses' experience and competence.

So, I feel that the physicians often rebuke the nurses. (Petra, 13 years)

And [the physician, author's note] almost starts to berate her [the nurse, author's note]… It is a young physician and the nurse has more experience and sees more […] and has more to do with people… (Petra, 13 years)

Although nurses and physicians had different roles and were on different hierarchical levels, complementarity was recognized. Physicians made the decisions. Nurses acted like go-betweens; they received important information and shared it with the physician and other health professionals. Subsequently, the nurses passed the new information back to the children.

Well, it is obvious who the physician is and who the nurse is… (Lilian, 17 years)

…because physicians and nurses take care of patients together, and then they talk about what happened. When the physician happens to run out of time, then the nurse takes over. (Rose, 13 years)

Of course, physicians are on top, but without nurses, it would not work. (Helen, 16 years)

It is possible that some information is difficult to accept or concerns difficult issues. Occasionally, information passed between physicians and nurses that was beyond the grasp of the children/adolescents. In such cases, nurses not only passed on information, they also adapted it so that the children/adolescents were able to understand it. Therefore, nurses act as "translators" in case the information is too complex.

The physicians tell the nurse, and the nurse explains it to me in more acceptable terms, because sometimes I am not ready or able to understand everything. (Helen, 16 years)

Defining collaboration
The participants described and defined collaboration based on their own experiences.

Well, if it was me working here, I would like to feel in warm environment, to have good relationships with everybody. Yes, it is important to get along well with everybody in such a hospital. (Lilian, 17 years)

Yes, that a person communicates effectively, and that you have a good relationship, and also that everything is well coordinated, everyone knows who does what. (Helen, 16 years)

Awareness of being a patient

Perceiving one's own role
When asked about their role in interprofessional relationships, the participants preferred to talk about their involvement in their care process. The children's/ adolescents' role was to be a patient. For some, this role was passive.

In the sense that I am the patient… That I do not have to do more than a patient should... Yes, that I did not have to provide any information... about my illness. (Sandy, 12 years, second interview)

Others, notably adolescents, tried to be more active. Two of them talked directly about their role in IPC as patients:

I think if the patient participates, or accepts his or her illness more readily, the treatment progresses much faster. (Susan, 15 years)

I always tried to join in, to make it easier for them [nurses and physicians, author's note]. I also tried to be more independent… That way, they have fewer problems to discuss with one another. (Tom, 14 years)

The children and adolescents maintained that they are important for the care process. Being a patient is essential. Without the patient, there would be no interprofessional relationships.

Yes, after all, it is all about me, when they work together or around the patient. Well, I think that I have a role… I am the most important, and they adapted to me… They made sure that they got the best for me. (Helen, 16 years)

Well, I think they are always a good team, but it also depends on the patient. (Susan, 15 years)

One child explained her powerlessness as a patient regarding hierarchical relationships. Only one girl (12 years old) felt that patients do not play an important role in interprofessional moments such as ward rounds. This participant underlined the importance of patients for the collaboration between professionals.

Well, I find that patients do not have a big role. Physicians and nurses may not have much to do without us, but... yes, patients do not have much to do during ward rounds for example. (Sandy, 12 years)

In some cases, the participant expresses the willing to get involved in the interprofessional exchange and to be assertive, but he/she does not dare to.

And when some say, 'it is because of anxiety', and you know this has got nothing to do with anxiety at all, but rather from constipation… in these cases, you have to be assertive. And if you are not, that is stupid. And many people are not able to be like this. I am not able, and then my parents have to step in… Sometimes, you just have to accept what the physicians say. But you know very well that it is not quite right. (Petra, 13 years)

This participant maintained that sometimes assertiveness was not possible, due to her status. In these cases, the parents were expected to step in as reinforcement.

Discussion

To our knowledge, this is one of the first studies exploring the experiences of IPC from the perspective of children/adolescents as well as their role within an interprofessional team during hospitalization. Overall, the participants reported a positive and caring experience, enabled by a caring environment and a multidisciplinary team. The members of the multidisciplinary healthcare team provided numerous activities (games, creative activities, teaching activities…). Within the healthcare professional team, it was important that nurses and physicians were complementary to one another and shared a respectful relationship. Nurses were seen to perform roles that physicians did not have time to assume: adopting a warm attitude and providing a reassuring, continuous presence.

For some children and adolescents, their relationship with nurses differed from the one with physicians. The relationship with nurses was close, personal and familiar. Nurses were expected to be cheerful and have time to play. These experiences were also described by other children and adolescents.[13] Nurses were described as go-betweens and translators and capable of taking over when physicians ran out of time. This may explicate the fact that the participants did not necessarily expect physicians to

take on the same role as nurses, or to play or have a close relationship with them.

The physicians were predominantly in charge of treatment, decision-making and monitoring. The complementarity between nurses and physicians was evident in moments of information sharing. This is not surprising given that information sharing is key in pediatric settings.[10,17,18] Nurses provided information in plain, understandable terms to the participants. Considering the complexity of information, the use of medical terms, and children's/ adolescents' potential inability to understand it, this is an important issue.[16,19] The study participants asked nurses for additional information when something was uncertain. Occasionally, the participants would also consult the nurses when they were not ready to hear certain information from the physicians. The participants were neither scared nor intimidated, nor reluctant to ask further questions as has been reported in other studies.[16]

The interactions between nurses and physicians were moments of collaboration, which involved respect but were also ruled by power dynamics. Despite complementarity, physicians were perceived to be on a higher hierarchical level. The physicians were the leading force, while nurses were described as back-up force. Children and adolescents based this perception on the social status and educational background of the physicians. The hierarchical relationship was tangible to the participants when the physicians ordered something to be done and the nurses made sure that this task was carried out. It was essential for children/adolescents to know that there was a leading force driving the "business". However, the leader needed to show a caring and respectful attitude. Holyoake's findings reported that children/adolescents perceived the hierarchy between nurses and physicians.[14] Unlike in Holyoake's findings,[14] the participants in this study did not only perceived the nature of the relationship between the nurses and physicians but also had expectations regarding the interprofessional relationships between both groups of professionals. The children and adolescents were relieved to note that physicians did not abuse their power. Interactions between healthcare professionals are a key dimension of IPC, which is regulated by factors such as autonomy and power dynamics.[9]

Power was found to negatively influence the relationship between nurses and physicians and to lead to disrespect. One adolescent (13 years) perceived one physician's attitude to be harsh and disrespectful towards the nurse. From the adolescent's perspective, the physician was abusing of his power. The nurse's expertise was not accepted. The adolescent felt concerned, uncomfortable, powerless, and not in a position to interfere in the relationship. Interestingly, the adolescent linked the perceived negative interprofessional relationship to persisting social representations concerning nurses and physicians and their educational backgrounds. Another participant also hinted at educational background as a reason for the perceived power of the physicians.

The observations of the participants regarding the quality of relationships and difference between status and role of nurses and physicians underline the importance of influencing factors such as relational interactions, hierarchy, power-sharing,[8,14,28] and social representations.[29] Also, interactions between nurses and physicians have the power to influence children's and adolescents' care experience during hospitalization. The interactions appear to be a contributing factor towards creating a respectful environment and promoting a positive and caring experience. According to the participants' accounts, the quality of interprofessional interactions between the nurses and the physicians influences the children's/adolescents' openness and wish to seek information. These relationships contribute to the way children and adolescents retain information about their health condition, treatment and progress. Therefore, making an effort of creating a caring environment through the adoption of a respectful and caring attitude towards each other, especially when interacting in the presence of children and adolescents, can be an important element for health professionals to foster IPC. However, while the consequence of an effective interprofessional relationship has largely been addressed by the children and adolescents, only one participant had highlighted the effect of ineffective interprofessional interactions. A deeper understanding of the effect of this type of breakdown was not possible in this study.

The role of the children and adolescents in the relationship between nurses and physicians could not be elucidated in detail. Most participants were more comfortable addressing their role in the care process rather than in IPC. Some participants considered their role in the care process as important and active. In these cases, the participants specified concrete ways of behaving in their role such as participating in their care in order to recover rapidly. Other participants described their role as minor. One girl (13 years) commented on her stance towards the health professionals. She was torn between her desire to be more assertive and her perceived incapacity, due to her young age. This girl explained that her parents had to take over when she was unable to take part in discussions concerning her condition, or in an interprofessional interaction which she perceived as negative. Children's or adolescents' preference concerning participation and involvement in decision-making, is associated with age [10,19] cognitive maturity and willingness to participate.[10] Evidence exists that some children/adolescents prefer for adults to make decisions in certain situations, while others want to be involved.[20] This might explain the restrained reaction of children and adolescents towards their

perceived and actual role. According to our findings, children/adolescents do not regard IPC or interprofessional relationships as a process, in which they take part. The participants' perception of IPC is influenced by the nurses' and physicians' social representations and reflects medical dominance. This underlines the fact that involving patients in IPC will require a profound paradigm shift, particularly in pediatric settings. It will involve a redefinition and a new understanding of the role of each actor, including the patient. Interprofessional moments need to be transformed into a caring experience, both for the children and adolescents and for the professionals. Without any change in the culture of interprofessional practices, patients may hold on to a classical view of IPC: a process confined to healthcare professionals, ruled by traditional dynamics and representations of power and hierarchy. This change involves moving away from a hierarchical and power relationship between physicians, nurses and patients.

Limitations and strengths

The children and adolescents in this study provided insights into their experience within an interprofessional team and their perception of collaboration, but the questions were focused only on the relationship between nurses and physicians. The focus on these two professions alone might be a limitation, preventing a global view of the reality of IPC in the clinical setting. In future, a more thorough understanding of the effects of breakdowns in interprofessional relationships on the behaviour and the attitude of children and adolescents is needed. Thus, a full scope of the effects of interprofessional collaboration can be obtained. This qualitative study included the views and experiences of children and adolescents. A mixed-method design, including observations of all the members of the team, would be relevant to assess the extent to which each member is committed to participating in collaborative practices, or willing to do so, to obtain a deep understanding of the attitudes, roles and expectations of each actor.

Conclusion

The findings of this study made it possible to view interprofessional relationships from the perspective of children and adolescents. Although IPC does not seem to be the main concern of the participants per se, it is essential for a caring environment to the hospitalized children and adolescents. The participants of this study addressed critical issues such as power relationships, hierarchy and respect, which are central concepts within existing models of IPC.[9,11] Indirectly, the participants provided their expectations of an effective interprofessional relationship. Despite the hierarchy and the perceived dominance of the physicians, due to their social status and educational background, the children and adolescents expected health professionals to behave respectfully towards each other. This helped to create a caring environment in which the children and adolescents feel comfortable. However, neither children nor adolescents perceive their role to be pivotal to interprofessional relationships. Current models of IPC focus predominantly on the determinants of IPC. According to our findings, issues related to creating a positive and caring environment need to be addressed in future research as the need for further studies on the effects of breakdowns in interprofessional relationship on the attitude and behaviour of children and adolescents. Thus, it will be possible to develop models of care that are centered on the person. These models of care need to provide a place and role in IPC that children and adolescents want and are ready to assume.

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