Health professionals' involvement of parents in decision-making in interprofessional practice at the hospital

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Abstract

Health professionals have the responsibility of involving parents in decision-making regarding children's healthcare. This is to ensure that healthcare is customised to meet children's and families' needs and preferences. There is inadequate knowledge about health professionals' role in involving parents in these decisions in interprofessional practice in hospital settings. The aim of this study was to explore health professionals' construction of the phenomenon of parental involvement in decision-making about children's healthcare at the hospital and to identify how parental involvement can be improved. This explorative, descriptive qualitative study within a constructivist research paradigm selected a purposive sample of 12 health professionals who participated in individual semi-structured interviews. This qualitative data was used to construct a description of this phenomenon. The health professionals described ethical dilemmas and challenges related to parental involvement in decision-making while also providing technically safe, justifiable healthcare. Individual health professionals' involvement of parents in decision-making and the intra- and interprofessional collaboration between health professionals seemed to be of great importance to increase parents' active involvement in the co-production of children's healthcare. Further research is required to confirm the findings for generalisation.

Keywords: Health professionals, interprofessional collaboration, parental involvement, coproduction of healthcare, qualitative study.

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Introduction

In many countries, parents have a legal right to influence and be involved in decision-making about their children's healthcare, according to theories of patient-centred care, family-centred care and patient involvement in healthcare decisions (Edwards, Davies, & Edwards, 2009; Elwyn et al., 2014; Smith, Swallow, & Coyne, 2015). This is to ensure that the healthcare is shaped and customised as far as possible to meet the children's and families' needs and preferences and thereby increase patient safety and quality of care (Elwyn, Frosch, & Kobrin, 2016; Khan et al., 2017; Shields, 2010). Thus, parents are important partners in the co-production and implementation of children's healthcare until their children can fully represent

themselves (Aarthun & Akerjordet, 2014; Smith et al., 2015). However, parental involvement in such decision-making is not sufficiently implemented (Aarthun & Akerjordet, 2014). Furthermore, there is inadequate knowledge about health professionals' (HPs) perspective regarding their role in involving parents in decisions about children's healthcare in interprofessional collaborative practice (Aarthun, Øymar, & Akerjordet, 2018a; Wyatt et al., 2015). More knowledge is therefore required to inform HPs about how to improve parental involvement.

Background

Over the last decades, health-related decision-making has become more complex because of the introduction of biopsychosocial theories and patient involvement in healthcare decisions as well as increased specialisation, interprofessional practice, and advanced treatment methods (Lipstein, Brinkman, & Britto, 2012; Ofstad, Frich, & Schei, 2014; Taylor, 2006; Wirtz, Cribb, & Barber, 2006). Accordingly, HPs bear the responsibilities of involving parents and children of diverse cultural backgrounds, health literacy, and socioeconomic status in decision-making regarding children's healthcare (Aarthun & Akerjordet, 2014). Literature indicates that parents perceive active involvement in these decisions to be demanding due to lack of information and an inadequate understanding of their children's health condition and the healthcare system (Aarthun, Øymar, & Akerjordet, 2018b). This implies that parents need individualised facilitation of involvement and support by HPs (Aarthun et al., 2018b). HPs' sensitivity to parents' capabilities and needs during involvement seems to influence the communication and relationship, and thereby affect parents' active involvement and coping abilities in decision-making (Aarthun et al., 2018a). This has the potential to promote parents' sense of coherence by strengthening their comprehensibility, manageability, and meaningfulness (Antonovsky, 2012), where personal influence and control over one's own life circumstances, together with a supportive environment, promote coping and health (Eriksson & Lindström, 2008; WHO, 2009). However, there is lack of knowledge about HPs' perspectives regarding their role in involving parents in such decision-making (Aarthun et al., 2018a; Wyatt et al., 2015).

In healthcare institutions with extensive intra- and interprofessional collaborative practice, such as in paediatric wards at hospitals, the decision-making processes are often complex (Ofstad et al., 2014; Elwyn et al., 2016). Patients may have interacting health challenges and decisions involving many professionals. In addition, the decision-making processes may take a relatively long time (Ofstad et al., 2014). Consequently, parental involvement in children's healthcare decisions at the hospital may be particularly challenging for HPs. Contextually, interprofessional collaboration is a process where different HPs work together in teams to make healthcare decisions as well as to implement safe, justifiable healthcare together with parents and children (Reeves, Pelone, Harrison, Goldman, & Zwarenstein, 2017). Decision-making may require collaboration that is interprofessional (involves different professionals) and intra-professional (individuals within the same profession). Furthermore, interprofessional collaborative practice is assumed to increase the quality of healthcare (D'Amour, Ferrada-Videla, San Martin-Rodriguez, & Beaulieu et al., 2005). However, collaborative practice is influenced by many factors, such as interactional, organisational, and systemic determinants (Légaré et al., 2011; San Martin-Rodriquez,

Beaulieu, D'Amour, & Ferrada-Videla, 2005). These factors may influence HPs' involvement of parents in children's healthcare decisions. There is, therefore, a need to study HPs' perspectives regarding parental involvement in children's healthcare decisions in the context of interprofessional practice.

The shared decision-making model is often used when involving parents and children (dependent on their age and maturity) in children's healthcare decisions (Kon, 2010). Accordingly, professionals, parents, and children expect to exchange information and reach a shared decision. In this study, parental involvement in decision-making regarding children's healthcare means involvement of parents in shared decision-making about individually customising of their children's examinations, treatments, and care (Aarthun & Akerjordet, 2014; Elwyn et al., 2017). Hence, HPs should facilitate information sharing and discussion of different opinions, including parents' preferences regarding their children's healthcare (Aarthun et al., 2018b). Decisions range from major decisions that impact patient safety and quality of healthcare to less important decisions, but still of significance for parents (Elwyn et al., 2017).

To summarise, more research is needed to increase our knowledge about HPs' perspectives regarding their role in involving parents in children's healthcare decisions in interprofessional collaborative practice at the hospital, including the identification of factors that can improve parental involvement in clinical practice (Aarthun et al., 2018a).

Aim

This study is designed within a constructivist research paradigm (Lincoln, Lynham, & Guba, 2013). The study aim was, therefore, to explore HPs' construction of the phenomenon of parental involvement in decision-making regarding children's healthcare at the hospital and to identify how parental involvement can be improved.

Methods

Research design

The study applied an explorative, descriptive qualitative design within a moderate constructivist research paradigm (Lincoln, Lynham, & Guba, p. 205, 2013) using a semi-structured interview guide to construct the phenomenon. The research paradigm assumes that knowledge is constructed in interactions of people where the meaning-making conversation is central (Holstein & Gubrium, p. 69, 2016). In addition, the ways in which the participants express and understand the world are historically and culturally embedded. The interview texts, thus, provide insights into the cultural and normative frames the participants use to make sense of their experiences and their social worlds (Miller & Glassner, p. 55, 2016).

The semi-structured interview method was considered appropriate in this study since it allows the interviewer to improvise follow-up questions based on participant's responses (Kallio, Pietilä, Johnson, & Kangasniemi, 2016). The interviewer can direct or promote the conversation or facilitate nuancing of statements and in-depth descriptions. In addition, the method gives the participant greater opportunities to influence the communication and express their own views in the interview. According to the research approach, the construction of the phenomenon was first analysed by studying the interactions, the construction of accounts, and the participants' expressed meanings in the interviews (Silverman, p. 443, 2014) (Table 2).

Second, to organise the participants' expressed meanings, qualitative content analysis was performed (Table 2) (Graneheim, Lindgren, & Lundman, 2017).

Recruitment of participants and setting

A purposive selection procedure was used to select participants at a university hospital in Norway (Silverman, p. 61, 2014). The sample of participants should consist of different types of HPs to correspond with modern interprofessional paediatric clinical practice. The inclusion criteria were:

1) HPs who interacted with parents and made decisions about children's healthcare; and
2) the sample had to represent different health professions such as registered nurses, physicians, physiotherapists and dietitians who worked in different paediatric wards within the hospital.

The paediatric department at the hospital had a neonatal ward, a general medical ward, and an outpatient ward. Interprofessional collaboration was stressed at department level, indicating that nurses, physicians, physiotherapists, and dietitians work in teams and collaborate in decision-making surrounding children's healthcare, including parental involvement. Additionally, each of the HPs were responsible for involving parents in decisions within their area of expertise.

The managers of HPs working at the paediatric wards were informed in writing about the study, and they informed professionals who met the inclusion criteria. Interested professionals contacted one of the researchers and participated in an interview. When sufficiently rich data were obtained and no new variation in knowledge appeared, no further interviews were conducted (Daly et al., 2007). This resulted in a sample of 12 interviews with 12 participants.

Interviews

The first author conducted eleven individual semi-structured interviews from February to July 2017 and one in March 2018. The interview guide was based on previous knowledge on the research topic (Aarthun & Akerjordet, 2014; Aarthun et al., 2018a) and theory of user involvement (Entwistle & Watt, 2006; Thompson, 2007). Two of the authors were involved in the preparation of questions to the participants. The main questions were: 'how do parents participate in decision-making about their child's healthcare in your practice at the hospital?', 'how do you involve and facilitate parents' involvement in decisions about their child's healthcare?' and 'what can be done to improve HPs' involvement of parents in decision-making about their child's healthcare at the hospital?' The interviews were conducted at the hospital, audio recorded, and lasted 45 to 75 minutes. The participants' background characteristics were acquired by a demographic survey. Notes describing the interview setting were made by the interviewer after the interviews.

Participants

The sample of participants is presented in Table 1 and had a good range in profession, age, additional education, and number of years of work with children.

Table 1. Description of participants

Profession	**Nurses**	**Physicians**	**Physiotherapists**	**Dietitians**
Number (male/female)	5 (1/4)	3 (1/2)	2 (1/1)	2 (0/2)
Age range	25–50 years			
Number of years working with children	3–21 years			
Number of years working at the paediatric department	2–21 years			
Education beyond qualification for the profession	2 nurses had more than one year of extra education. 1 physiotherapist was specialized in paediatric physiotherapy. All the physicians were paediatricians and 1 had a PhD-degree.			
Worked at the following wards	2 nurses worked at the neonatal ward and 3 nurses at the general paediatric ward. The physicians worked at the neonatal ward or the general paediatric ward in addition to the outpatient ward. The physiotherapists and dietitians worked at all the wards.			

Data analysis

The recorded interviews were transcribed verbatim with signs for breaks and descriptions of sounds from the participants and interviewer. Identifying details were anonymised or removed. The first part of the analysis was performed according to Silverman (p. 198, 2014), shortly described in Table 2.

Table 2: Overview of the analysis.

First part of the analysis according to Silverman (2014).	The construction of the phenomenon. 1) The transcript of each interview was read. The text was divided according to sequences of meaning-making about subjects. 2) The interactions and how the construction of accounts about the research topic in each interview were analysed. 3) The results from the study of the account construction were analysed and led to the construction of cultural stories about the phenomenon. 4) The meanings the participants attached to their accounts about the research topic were explored. This interpretation led to the cultural stories.
Second part of the analysis according to Graneheim et al. (2004, 2017)	Qualitative content analysis of the cultural stories. 1) Relevant text was extracted and divided into meaning units. 2) The condensed meaning units were coded and compared which resulted in preliminary subcategories and categories. 3) Further analyses with a higher degree of abstraction resulted in the findings of one main category and three subcategories.

First, each transcript was read several times to get an impression of the interview and the setting. Important additional empirical resources were the notes describing the interview settings. The transcript texts were divided into parts where each part contained a sequence of meaning-making about a subject. Second, a thorough analysis of the transcribed interviews was conducted, using analytic induction (Silverman, pp. 183-202, p. 95, 2014). The interaction and how the construction of accounts about the research topic in each interview were studied, while temporarily setting aside attention to which meanings the participants attributed to their statements and experiences. Thus, construction activation, positioning of the participants, identity work, and function of statements and narratives were analysed. Third, relevant results from the study of account constructions were compared and interpreted by identifying similarities and differences. This led to the results of the construction of cultural stories about the phenomenon (Silverman, p. 189, 2014). Fourth, the meanings participants attached to their accounts of the research topic in the interviews, based on the account construction, were explored (Shopes, p. 133, 2013). This interpretation led to the cultural stories that were the researchers' interpretations of the participants' expressed meanings in the interviews (Altheide & Johnson, p. 396, 2013; Silverman, p. 189, 2014).

The second part of the analysis, described in Table 2, was a qualitative content analysis of the cultural stories. First, the cultural stories from the interviews that were relevant for answering the research questions were extracted and divided into meaning units (Graneheim & Lundman, 2004). Second, in accordance with Graneheim et al.'s (2017) qualitative content analysis, the condensed meaning units were coded and compared for similarities and differences and resulted in preliminary subcategories and categories. Third, further analysis resulted in one main manifest category and three subcategories, illustrating a descriptive version of the cultural stories about the phenomenon in the interviews (Table 3).

Table 3. Findings from the qualitative content analysis of the cultural stories about the phenomenon.

Preliminary categories	**Subcategories**	**Main category**
Parental influence. Parental involvement.	Parental involvement and influence.	Facilitating parental involvement
Health professionals' involvement of parents.	Health professionals' facilitation of parental involvement.	
Intra- and interprofessional collaboration.	The impact of intra- and interprofessional collaboration.	

The first author (AA) performed the analysis of the interviews and cultural stories. The other authors assessed the analysis critically and agreed to the final composite analysis.

Ethical considerations

The study is in accordance with the Declaration of Helsinki (World Medical Association, 2013). It was approved by the Regional Ethics Committee (2013/1603B) in Norway and the university hospital's internal commission, the management of The Department of Paediatrics, and the Director of Research (Nov/Des. 2013). The participants received information about the study, and were informed about voluntary participation, the possibility of withdrawing from the study, and the guaranteed confidentiality. Written informed consent was provided by all the participants. Anonymity is secured by not furnishing identifying information about the participants in the description of the sample and where quotations are used in the findings section.

Findings

The findings indicate that the HPs were concerned about parental involvement in decision-making as well as shaping and providing technically safe, justifiable healthcare to the children. They regarded parents as important actors in decision-making about children's healthcare. However, their responsibility for the quality of healthcare could cause ethical dilemmas and challenges during parental involvement. The quality of HPs' involvement of parents in decision-making and the intra- and interprofessional collaboration seemed to be of great importance to increase parents' active involvement in the co-production of children's healthcare. The main findings are presented according to the data analysis in table 4.

Table 4: Main findings.

The construction of cultural stories about the phenomenon	**Summary of cultural stories about the phenomenon** *'Facilitating parental involvement'*
Several of the health professionals were concerned about parental involvement in decision-making as well as shaping and providing safe, justifiable healthcare to the children. Their responsibility could cause ethical dilemmas and challenges during parental involvement. Some health professionals were less aware of parental involvement in children's healthcare decisions.	*'Parental involvement and influence':* The health professionals regarded parents as important actors in decision-making about children's healthcare. They needed to involve parents in decision-making in order to shape an individually customised and safe, justifiable healthcare.
	'Health professionals' facilitation of parental involvement': The quality of parents' involvement seemed to depend on how health professionals involved and facilitated their involvement, which was influenced by the HPs' competencies. During parental involvement, the health professionals emphasised good communication and relationship with the parents.
	'The impact of intra- and interprofessional collaboration': The quality of intra- and interprofessional collaboration seemed to affect quality of healthcare and parental involvement. Health professionals' competencies appear to influence the quality of intra- and interprofessional collaboration.

<u>The construction of cultural stories about the phenomenon</u>

As initially stressed, the findings indicate that several of the HPs were concerned about parental involvement in decision-making as well as shaping and providing technically safe, justifiable healthcare to the children. The participants mostly positioned themselves as competent HPs who facilitated parental involvement in decision-making about children's healthcare at the hospital. They talked about how they involved parents in such decision-making and emphasised different aspects. A physician described how she involved parents in their child's healthcare decisions by asking them questions about her suggested healthcare. The following was said:

Interviewer: 'How do parents participate in decision-making about their child's healthcare in your practice at the hospital?'
Participant: 'The parents come with their child and speak about him/her, answer questions, and we make a plan (about the healthcare) out of what we have talked about and what we found (in the examination). I think and hope that we ask the parents about what they think of the plan. (I ask questions as follows). Does this sound okay? What do you think of what I am saying to you? I think those are words I often use. (I also ask them) whether they recognise the findings. (Other questions I ask are,) what do you think about what I am telling you? Is this something that you think you can participate in? So, there is a kind of lead from me. That's what it is'. (10)

A physiotherapist said that she involved parents in decision-making about customising their child's physiotherapy by informing them thoroughly about her findings and recommendations for improving their child's health condition and development. Another physician said that she usually asked parents what they thought was important for their child and emphasised their preferences in decision-making about their child's healthcare. However, some of the HPs expressed that they were little aware about parents' codetermination regarding their child's healthcare. The following was said:

Interviewer: 'How do parents participate in decision-making about their child's healthcare in your practice at the hospital?'
Participant: 'Oh, I have never thought of it. Thus, it is a bit difficult to explain how I do it. Yet, I don't know whether they are involved so much'. (6)

Another example:

Interviewer: 'How do you involve parents in decision-makings?
Participant: 'I think I'm not that aware; thus, perhaps I should be more aware of how I involve parents'. (9)

Furthermore, several HPs did not appear to always distinguish between parental involvement in decision-making about shaping their child's healthcare and parental involvement in implementing their child's healthcare. Several talked about how they involved parents in implementing their child's healthcare by educating on the care and physiotherapy actions, instead of how they involved parents in decision-making about the healthcare. Despite the fact that the interviewer asked follow-up questions about parents' codetermination and involvement in decision-making, several HPs continued talking about how to involve parents in implementing the healthcare.

In addition, the HPs positioned themselves as preoccupied with shaping and providing safe, justifiable healthcare to the children. This responsibility could cause ethical dilemmas and challenges when involving parents in children's healthcare decisions, especially when parents' preferences and suggestions were not considered as technically safe and justifiable. This was said in an interview:

Interviewer: 'What have you done when you haven't reached agreement with the parents about the healthcare?'
Participant: 'Then I have collaborated with the HPs in the primary care to ensure that the child gets the healthcare he/she needs from a technical point of view. However, I know colleagues have had very difficult cases where the parents have opposed physiotherapy. They have then had an interprofessional discussion about the limits of parents' decisions about their child's healthcare. In addition, they have discussed the need of reporting it to child welfare. It's the parents who decide which actions to implement'. (3)

In these cases, it had been difficult to reach an agreement with the parents about their children's healthcare. It had been demanding for the HPs to decide the limits of when the healthcare was not technically safe and justifiable, because their decision could be significant for both the child and the parents. In grave cases, the HPs had to send a worrying message to

child welfare because HPs have an obligation to do so when parents do not take care of their child's needs.

Another challenge connected to providing technically safe, justifiable healthcare was the involvement of parents' in decision-making about how to carry out important and necessary medical examinations and treatments in a gentle way for the children. An example was whether and how to use coercion with children who resist an examination. Although use of coercion was easier when the parents agreed and supported the implementation, a senior nurse said the following:

'I think the parents should have a big influence on their child's healthcare. A good example is the use of coercion. When we have to perform blood testing. Oh, I often think it's difficult. The child opposes. The parents cooperate with us. Nevertheless, where is the limit of holding the child? Then I try to get eye contact with the parents and ask: Should we continue? Or should we stop? I think it's very difficult. There isn't any set answer'. (1)

She also said:

'I think they know their child best. They know in a way how much the child tolerates. How much we can pressure the child, so he/she doesn't get traumatised'. (1)

A nurse talked about another contextual challenge:

'Challenges are often that the children decide a lot themselves. I think it's challenging when the parents negotiate and try to get their child to want to participate before they must participate in an examination. Sometimes they will never want to participate. After some years of experience, you know that they will have to negotiate for a long time to get a yes from some children. Is it more gentle for the child to negotiate, cry and scream for two hours? Nevertheless, at the end we'll have to hold the child'. (9)

Another dilemma was when parents assumed that an examination or treatment was painful and said, when their child heard about it, they thought that their child would not let the HPs examine or treat their child. These parents often worsen the performance of necessary examinations or treatments, and it was difficult to cooperate with them to find a gentle way of conducting the health tasks. For example, one participant noted a parent said that they did not think their daughter would let the HPs put a pH-probe into her oesophagus. Some nurses expressed that they tried to carry out the medical examination the physician had ordered, but sometimes failed to do it. This did not fit with their attitudes and routinised thinking towards their own professional roles such as implementing the examinations or treatment tasks the physicians had ordered. On the other hand, some of these HPs expressed little about how to involve parents in these decisions and how to be more aware of judging their use of coercion, in accordance with implementing technically safe, justifiable healthcare.

Summary of cultural stories about the phenomenon

The findings are illustrated in one main category, 'facilitating parental involvement', and three sub-categories: 'parental involvement and influence', 'HPs' facilitation of parental involvement', and 'the impact of intra- and interprofessional collaboration'. The findings

indicate that the HPs regarded parents as important actors in decision-making about children's healthcare at the hospital. Additionally, the quality of HPs' involvement of parents in decision-making and the quality of intra- and interprofessional collaboration seemed to influence parental involvement.

Parental involvement and influence.

The HPs expressed that they needed information from parents about their child's and their own needs and preferences to be able to shape an individually customised healthcare plan. A physician said:

'I think it's very important that I have a dialogue with the parents. It's vital in my job to establish contact with the parents because it's significant for the facilitation of getting further and do what's best for the child'.
Interviewer: 'Is it necessary for shaping a customised healthcare?'
Participant: 'Yes, we can't manage that without the parents help'. (10)

Furthermore, the quality of children's healthcare was often dependent on parents' assistance in implementing the plan, because of the children's care needs and limited healthcare resources. This required that the HPs and parents reached an agreement about the child's healthcare and that the parents were motivated and had the opportunity to assist in implementing the healthcare. A physiotherapist said:

'...if the healthcare we recommend is very different from what the parents prefer or wish, then it is very difficult to implement a good treatment because they will not be team players. They don't have an understanding of why the treatment is needed and therefore can't implement the treatment'. (4)

The HPs reported that parents were involved in decisions about the individual adaptation of examinations and treatment plans, for example, care, medical, physiotherapeutic and nutritional plans. They were less involved in medical decisions about medication except for the parents of children with long-lasting special conditions. These parents often had a lot of knowledge about their child and their condition. Parents of children with critical life-threatening conditions were also involved thoroughly in the medical treatment process to ensure that they received adequate information about the child's condition and healthcare. In addition, it included getting parents opinions about ending the life sustaining treatment if it became a necessity.

The HPs expressed that parents had a lot of influence on shaping their child's healthcare. They were forthcoming regarding parents' preferences such as parents' preference of a special diet or timing for implementing examinations and treatments. Several expressed that they accepted alternative treatment methods, as long as it did not affect the child negatively. Nevertheless, the wards' limited resources affected the HPs' accommodation of parents' wishes regarding how long parents had to stay with their children at the hospital. This led to conflicts with some parents of children with long-lasting hospitalisations.

HPs' facilitation of parental involvement.

The findings indicate that parents' involvement in decision-making regarding children's healthcare was dependent on how HPs involved and facilitated the same. The parents were usually involved in dialogues and discussions about the individual customisation of their child's healthcare. The HPs emphasised promoting parents' understanding of their child's health condition, needs, and the recommended healthcare, by giving them individually tailored information. One physician said:

'It's important to ensure the parents receive the information they need and have a right to get so they understand the background for the decisions. Additionally, they can raise objections'. (12)

The parents at the neonatal ward were involved early in their child's care, which promoted their attachment to their child and thereby increased their engagement in shaping and implementing their child's healthcare.

The HPs tried to facilitate good communication and relationship with the parents. One physician at the neonatal ward said:

'.. we start very early to involve parents in decision-making about their child's healthcare. I think it's important to talk a lot with the parents. That we don't only have one meeting with the physician per week'. (11)

Furthermore, the HPs stressed the importance of frank and respectful communication, honesty, and responsiveness to what parents expressed. Additionally, they emphasised exchanging sufficient information about the child and healthcare and promoting dialogue with the parents. To increase parents' understanding, they repeated the information and provided it in different ways, such as verbally in different settings and through writing in informational material. However, some professions were short of informational material due to lack of resources. Some of the HPs expressed that they were aware of the asymmetric relation in power when involving parents particularly those with little resources. Other HPs were less concerned with this.

Usually the HPs recommended healthcare and enquired parents' opinions about this. Mostly, the parents agreed to the recommended healthcare. However, a physician said:

'I think we, HPs, have to be very aware of what we say, how we express ourselves because in most cases the parents listen to our recommendations and agree to them'. (12)

Nevertheless, the HPs reported some cases where it had been particularly challenging to come to an agreement with parents about their child's healthcare. The parents then preferred healthcare that the HPs' considered not to be technically safe and justifiable. Examples of cases of disagreement were parents who had been opposed to physiotherapy and parents who wanted an alternative medical treatment. In such cases, the HPs provided parents with a lot of information and argued for their opinion about the healthcare. In addition, they tried to find alternative solutions. They used a lot of time in dialogue with parents trying to come to an agreement.

Several of the HPs tried to be sensitive and responsive toward parents' needs and preferences regarding their child's healthcare. However, what parents considered as important could be different from what HPs considered to be important. Some of the HPs had, therefore, facilitated parents to speak about what they thought was important, resulting in greater awareness of parents' preferences. Other HPs said they ought to emphasise this more. On the other hand, others expressed that they could not manage this in their busy clinical practice.

Several HPs reported that time constraints influenced their facilitation of parental involvement in children's healthcare decisions negatively. Furthermore, several spent much more time and often did not achieve high enough quality of involvement when involving parents with language and cultural barriers. In addition, the room condition at the wards reduced HPs' opportunities to involve parents in their child's healthcare decisions.

The impact of intra- and interprofessional collaboration.

The findings indicate that the quality of intra- and interprofessional collaboration seemed to affect parental involvement. Less integrated intra- and interprofessional collaboration appeared to influence the continuity of healthcare and parental involvement in children's healthcare decisions negatively. Inconsistent information and disagreement between HPs, both intra- and interprofessional, about the healthcare made it particularly demanding to make parents understand information about their child's health condition and needs and be actively involved in decision-making. Reduced workforce affected the organisation of the HPs and led to frequent changes of HPs, which was negative for the interaction with parents and the continuity of healthcare. This led to many changes in the children's plans for examinations and treatments because the HPs had different views of what kind of healthcare were best for the children. The parents then became insecure and frustrated. This made it particularly demanding for the HPs who tried to recover continuity of care and parents' trust in the recommended healthcare. Several of the HPs expressed that to avoid fragmented healthcare, the agreed upon recommendations ought to be described clearly and argued for in the children's health record and changed only when there were good reasons. Furthermore, continuity of healthcare required that the HPs were well-prepared for their consultations and updated about the children's health condition and healthcare. Mutual understanding and intra- and interprofessional continuity in the healthcare were promoted when the HPs respected and followed the ward's procedures on diagnoses, examinations, and treatment. Moreover, the intra- and interprofessional meetings were important to promote a good collaboration and continuity in healthcare. One nurse said:

'If one of us have special challenges with some parents, we get together and discuss the case. However, we should have done more of this in the mornings'. (5)

Nevertheless, in busy periods the HPs discussed and shared less information about the healthcare of children for whom they shared responsibility. This reduced the collaboration and continuity of healthcare.

The HPs expressed that their technical competence influenced which professional recommendations parents received about their child's healthcare, such as with promoting breastfeeding. One nurse said:

‘However, when it comes to decisions about care to promote attachment and breastfeeding then there are many weakly founded opinions. It’s not always evidence-based. We should practice according to evidence-based knowledge, but we don’t always do that’. (2)

Different opinions of what was best to do for a child reduced the extent of agreement between the HPs, both intra- and interprofessional, and thereby continuity in healthcare. In addition, HPs’ technical competence and evolving professional literature affected their judgements of new and alternative treatment types. Based on this, the HPs ought to be technically updated according to evidence-based practice.

The HPs expressed that well-functional intra- and interprofessional collaboration was particularly important when there were challenges in involving parents in decision-making. Examples of this were parents with language and cultural barriers, parents with little resources, and parents to children with special health conditions. In such cases, the nurses tried to identify what the parents understood of the information provided about their child and their preferences. Based on this, they discussed the case and reached an agreement about a strategy to support the parents in decision-making and implementing their child’s healthcare. Furthermore, when the HPs did not come to an agreement with the parents about their child’s healthcare, they discussed the case with their intra- and interprofessional colleagues to ensure that they made a good, technically justified decision on the healthcare. Sometimes, they needed support to influence the parents or to find alternative solutions. Different professional perspectives and approaches in well-functional intra- and interprofessional collaboration seemed to promote the relationship and communication with parents. In addition, the collaboration could help find new solutions when there are disagreements with parents.

Several of the HPs expressed that they preferred an interprofessional approach because it provides a more holistic offer and often accommodates parents’ preferences and thereby qualitatively better healthcare. Many HPs, therefore, preferred interprofessional consultations. The parents then got a better opportunity to ask questions and discuss the healthcare with the involved HPs. Nevertheless, in such settings, it could be difficult for parents to express their objections, especially when the HPs appeared to agree about the healthcare. In such cases, some of the HPs tried to be extra responsive to parents’ needs and preferences and supported them during the interprofessional discussion of their child’s healthcare.

Discussion

The findings provide insight into the cultural and normative frames HPs at the hospital use to make sense of their clinical practice (Miller & Glassner, p. 55, 2016). Study participants sought to involve parents in their child’s healthcare decisions and shape technically safe, justifiable healthcare for the children. They needed information from the parents about the child and the family to individually customise the healthcare. In addition, they needed parents’ assistance in implementing the care to be able to provide high quality healthcare. However, how the HPs involved parents in these decision-making processes seemed to affect parental involvement and be influenced by the HPs’ competence. In this regard, some HPs were less aware of their professional role in involving parents in these decisions. Moreover, the quality of intra- and interprofessional collaboration seemed to affect parental involvement and quality of healthcare.

The HPs needed information from parents about their child and family as well as parents' assistance in implementing the healthcare to be able to shape and provide high quality healthcare. This is consistent with previous research (Coyne, 2013; Harrison, 2010; Watts et al., 2014). Furthermore, this required that the HPs and parents made a shared decision about the children's healthcare. Usually, the parents agreed with the HPs' recommended healthcare (Smith, Cheater, Bekker, & Chatwin, 2013). Accordingly, involving parents in children's healthcare decisions was then not a challenge. However, involvement of parents in their child's healthcare decisions became a big challenge when parents rejected the recommended healthcare and preferred care that the HPs considered not to be technically safe and justifiable, or fit with the wards' frames (e.g., routines, procedures, HP resources, room conditions).

Contextually, how HPs practiced their accountability and judgement of whether children's healthcare was technically safe and justifiable, and managed their authority and power, was of consequence for parents' involvement in and influence on their child's healthcare. The HPs' relationship with parents was asymmetric due to parents' dependence on how HPs involve them in healthcare decisions (Aarthun & Akerjordet, 2014). Other reasons for the asymmetric relationship are HPs' knowledge about healthcare and the healthcare system, and their power regarding deciding the distribution of available healthcare resources (Aarthun & Akerjordet, 2014; Bærøe, 2009). How HPs use their power when involving parents in children's healthcare decisions is of utmost importance regarding parents' active involvement. Consequently, this requires HPs' consciousness and presence to ensure quality and safety of children's healthcare. According to the findings, HPs' awareness about their power position and how they practiced parental involvement varied, which corresponds with the literature (Aarthun et al., 2018b; Smith et al., 2013). Furthermore, HPs' attitudes to parental involvement in decision-making may affect this and are influenced by their professional paradigm such as their understanding of causality related to health and disease (Aarthun & Akerjordet, 2014). High quality intra- and interprofessional collaboration may be of significance to decrease evident asymmetric parent-HP relationship.

Another factor that seemed to influence HPs' involvement of parents in children's healthcare decisions was HPs' competence, such as their knowledge about parental involvement in children's healthcare decisions, and communication and relational skills (Aarthun & Akerjordet, 2014; Aarthun et al., 2018a; Land, Parry, & Seymour, 2017). Consequently, this sets high standards for HPs' communication and relational competencies, and knowledge about parental involvement in healthcare decisions. In addition, HPs should become more aware of how and when they involve parents (Aarthun et al., 2018b). This also applies to decisions about how to implement examinations and treatment that the children oppose. Time constraints because of poor workforce, and lack of suitable room conditions at the wards limited and challenged HPs' involvement of parents in decision-making (Aarthun & Akerjordet, 2014; Smith et al., 2013; Coyne, 2013). This implies, that sufficient resources are a necessity for facilitating parental involvement in children's healthcare decisions.

The quality of intra- and interprofessional collaboration seemed to affect parental involvement in children's healthcare decisions and the quality of healthcare. An interprofessional approach was noted to accommodate parents' preferences to a greater extent. Well-functional intra- and interprofessional collaboration about shaping and implementing

children's healthcare appeared to increase continuity of healthcare and promote parents' confidence in the healthcare. These findings reflect the literature about patient involvement in healthcare decisions (Carman et al., 2013; Körner, Ehrhardt, & Steger, 2013; Légaré et al., 2011), yet it lacks clear evidence according to Reeves et al. (2017). The findings showed that HPs' competencies and opportunities for regular intra- and interprofessional meetings were regarded as important for improving the quality of collaboration and continuity of healthcare (Reeves et al., 2017). Furthermore, the quality of intra- and interprofessional collaboration appeared to influence the collaboration about involving parents in decision-making. In demanding cases of parental involvement in decision-making, the HPs received important support from intra- and interprofessional colleagues, such as discussing the cases, influencing the parents, and finding new solutions. The HPs can, thus, utilise collaborative processes to meet the challenges and complexity in parental involvement in children's healthcare decisions (D'Amour et al., 2005). The findings indicated that the complex intra- and interprofessional collaboration practice should be improved by strengthening the collaborative communication and relationship between the HPs and HPs' role understanding (Körner et al., 2013; Légaré et al., 2011). HPs' adherence to recommended practices and organisational routines should also be improved (Reeves et al., 2017). However, the findings indicated that reduced workforce reduced the intra- and interprofessional collaboration and thereby the continuity of healthcare (Körner et al., 2013). Sufficient resources and support from health managers is, therefore, required.

Limitations and further research

This study was conducted within a moderate constructivist research paradigm (Lincoln et al., p. 205, 2013), and the researchers sought to achieve trustworthiness and scientific rigor throughout the entire research process. Nevertheless, the study process and results are influenced by the authors' professional competencies, context, and local culture (Altheide & Johnson, p. 382, 2013). The authors have experiences as clinicians, such as paediatric physiotherapist, critical care nursing and paediatric medical practice in various hospital settings. The interviewer's background as a paediatric physiotherapist and familiarity with the included hospital wards influenced her pre-understanding and interaction, follow-up questions, and construction of the phenomenon in the interviews. Knowledge about the culture and institution can be regarded as an advantage, when considering asking questions about the research topic that obtain important information, or as a disadvantage, because the knowledge can make you blind to other perspectives.

Since this is a self-selected sample of providers who are very highly aware of their need to involve parents in children's healthcare decisions, they may be biased against their self-competence and hence the findings are not yet generalisable to all HPs. Nevertheless, the study is helpful to generate themes that need to be further evaluated using different study design, which can examine the bias of the interviewer and interviewee towards their self-competence (Polit & Beck, 2010).

Concluding comments

This study contributes new knowledge about HPs' roles and challenges in involving parents in children's healthcare decisions in interprofessional practice. It especially adds new knowledge

about HPs' challenges in combining the shaping of a technically safe, justifiable healthcare to children and the involvement of parents in these decisions. The quality of HPs' facilitation of parental involvement and the intra- and interprofessional collaboration seemed to be of great importance to increase parents' influence in the co-production of children's healthcare. According to this, health managers should facilitate health professionals' involvement of parents in decision-making and the intra- and interprofessional collaboration within hospitals. Sufficient resources and strengthening of HPs' role understanding and their collaborative communication and relationship, are needed. However, further research is needed to confirm the findings for generalisation. Other directions for future research are more research about the intra- and interprofessional collaboration within hospitals and about parental involvement in decision-making amongst migrant parents with language and cultural barriers. In addition, more knowledge is required to understand how children are involved in their healthcare decisions and how this influences parental involvement.

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