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Review Article

Transition from Family-Centred to Child-Centred Care in Pediatric Nursing

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ABSTRACT

The position of children in society is constantly evolving and being questioned. This inquiry includes issues related to the position of children in health care and the models of care used. Whatever the name given to the evolving approach to children's care (child-centered care, family- and child-centered care, or child- and family-centered care), children's rights to be active participants and active partners in their health care with their parents must be protected. This review aims to present the main strengths, benefits, and challenges of the family-centered care approach, explain the potential philosophical underpinning of the child-centered care approach, how it can be considered in conjunction with family-centered care, and what it means for children, families, and health professionals, and its implications for clinical nursing practice.

Keywords: Child, Child-centred care, Family-centred care, Parent, Right to participation

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INTRODUCTION

Family-centered care is an approach that supports parental involvement in care for the emotional and physical development and well-being of the child. This approach was initially proposed to reduce the negative effects of hospitalization for both children and parents and to support parents to optimize the care they provide (Bowlby, 1951; Robertson, 1958). Child-centered care is a new concept in health care services and has not yet been defined (Ford et al., 2018). The child-centered care approach in nursing was first proposed at a family-centered care workshop with nurse academics in Lund, Sweden in October 2014 (Coyne et al., 2016). Often family-centered care can lead to a more passive and less prominent role than that of the parent(s), even if a more active involvement of the child is possible. Child-centered care puts the child first by focusing on the child (in the family context), where the focus tends to be on the parents and the child's perspective is secondary. There should not only be a strong focus on the family as the main reference point for children but also a recognition of the wider environment in which children are involved and their relationships outside the family. It has therefore been argued that a new conceptual framework needs to be developed that recognizes the position of the child in relationships within and outside the family, elevating the child to a more prominent role as a key and active member in relationships (Carter et al., 2014). This review aims to identify the main strengths, benefits, and challenges of the family-centered care approach, explain the potential philosophical basis of the child-centered care approach, how it can be handled together with family-centered care, and what this approach means for children, families, and health professionals, and to explain the implications of this situation for clinical nursing practice.

FAMILY-CENTERED CARE

Family-centered care is a philosophy of care that puts the patient and the family at the center of all health care decisions (W. Smith, 2018). The Institute for Patient and Family Centered Care defines family-centered care as 'mutually beneficial partnerships between health care providers, patients, and families in health care planning, delivery, and evaluation (Institute for Patient and Family Centered Care, 2004). Family-centered care is a model of care promoted in the care of sick children and has been proposed to meet the needs not only of the child but also of family members (Kokorelias et al., 2019; Watt et al., 2011). Hospitalization of the child may cause parents to move away from their parental roles as they transfer the role of being the primary caregiver of their children to healthcare professionals. In addition, parents want to be with, care for, and support their children in the hospital. The active involvement of parents in the care of the hospitalized child constitutes the basic structure of the philosophy of family-centered care (Frost et al., 2010).

Family-centered care has been defined as 'care planned by health personnel for the whole family, not just for a single child (Shields et al., 2012). According to this definition, family-centered care is a joint synthesis of nursing, with key qualities defined as building trust, listening to parents' concerns, and valuing parents' knowledge about their children (J. Smith et al., 2015). Family-centered care involves working in partnership with a family and caring for children in a family context. In this care, health professionals are expected to create the right environment for the child with appropriate steps and recognize and strengthen the specific knowledge and skills of families (Coyne et al., 2016).

Principles of Family-Centered Care

To date, a consensus definition of family-centered care practices and actions has not been achieved (Bamm & Rosenbaum, 2008; Jolley & Shields, 2009). However, an important agreement has been reached on the principles of family-centered care developed by institutions such as the Patient and Family Centered Care Institute, the American Academy of Pediatrics and the Maternal and Child Health Bureau (Committee on Hospital Care, 2003; Institute for Patient and Family Centered Care, 2004; Maternal and Child Health Bureau, 2023). The general principles agreed upon are shared as follows:

- ***Information Sharing*:** Information exchange should be open, objective, and impartial (Coyne et al., 2016; Kuo et al., 2012).
- ***Respect for Diversity and Dignity*:** Respect for individuals' differences, cultural and linguistic traditions, and care preferences (Coyne et al., 2016; Kuo et al., 2012).
- ***Partnership and Collaboration*:** Decisions that best fit the child's needs, strengths, values, and abilities and are medically appropriate should be made together (Coyne et al., 2016; Kuo et al., 2012).
- ***Negotiation (Participation)*:** Expected outcomes of care plans may vary according to the individual (Coyne et al., 2016; Kuo et al., 2012).
- ***Care in the Context of Family and Community*:** Medical care and decision-making are related to the child, his/her family, home, school, daily activities, and quality of life in the community (Coyne et al., 2016; Kuo et al., 2012).

These principles are significant issues for parents, but they do not directly apply to children. As between health professionals and families, there is often an asymmetrical balance of power in the relationship between parents and children. The needs of the family and the needs of the child may not be in sync. In this case, the dominance of the parents and the health professional establishes an asymmetrical relationship towards the child, which shifts the focus away from the child (Hallström et al., 2002a, 2002b). In addition, focusing on strengthening families' knowledge, skills, and ways of coping can potentially prevent the needs of the child from being taken into account. Kelly et al., (2012) argue that parents are the key players and focal point in family-centered care at the expense of children and that '*when the emphasis is shifted to parents as consumers of pediatric health care, children risk being objectified and even marginalized*'.

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Benefits of Family-Centered Care

Family-centered care has benefits for children, families, and health professionals. These benefits, which produce better health outcomes, are shown in Figure 1. Other benefits of family-centered care include reduced length of hospital stay and readmission rate, lower health care costs, more efficient allocation of resources, reduced medical errors, reduced legal issues, and greater patient, family, and health professional satisfaction (Söyünmez & Koç, 2020).

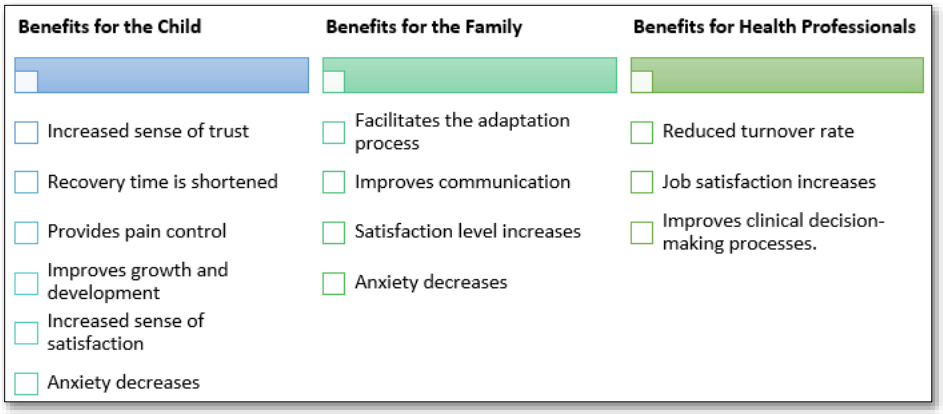

Figure 1. Benefits of Family-Centered Care (Öztürk Şahin, 2020)

Criticisms of Family-Centered Care and Problems in Its Use

Family-centered care has contributed to a shift away from clinically oriented approaches to providing care for children. However, despite its claim and prevalence as the underpinning approach to child care, it *remains a partially mature and rather abstract concept* (Mikkelsen & Frederiksen, 2011) and is subject to increasing criticism (Carter et al., 2014; Mikkelsen & Frederiksen, 2011; Shields et al., 2012). These criticisms are wide-ranging and often include a lack of evidence on the effectiveness of family-centered care (Mikkelsen & Frederiksen, 2011; Shields et al., 2012). Other criticisms are that more contemporary models of family-centered care continue to focus on attachment theory rather than keeping pace with evidence-based on a more robust, theoretically driven approach supported by a broad range of interdisciplinary knowledge (Tallon et al., 2015).

The most widely used measure of family-centered services, the Measure of Processes of Care (MPOC-20), focuses entirely on parents' experiences of care processes. Despite this, the MPOC-20 is proposed to be used as a measure of family-centered care, failing to acknowledge that it is a parent measure and failing to note the perspectives of the child, who is assumed to be at the center of care (Joachim et al., 2016). As good as it is, the MPOC-20 is at best a parent-focused measure of family-centeredness, with one parent, usually the mother, acting as a proxy for the 'family'. Findings from studies using the MPOC-20 suggest that although family-centered care underpins many/most practice settings, practitioners are still not getting things thoroughly right for parents/families and the provision of generic information is continually assessed as a need for improvement (Cunningham & Rosenbaum, 2014; Molinaro et al., 2017).

Evidence from the literature suggests that there is a significant difference between what family-centered care should be and what actually happens in practice settings (Ford et al., 2018; Khajeh et al., 2017). However, the most significant unperceived problem with the current framework and practice of family-centered care *is that too often the focus is on collaboration between professionals and parents and the focus on the child is lost* (Ford et al., 2018). This means that the child's voice is largely unheard and their subjectivity ignored. He draws attention to the tendency of professionals dealing with children to adopt an "*adult perspective, ignoring the child's perspective*" and argues that addressing this requires envisioning and embedding different ways of working at all institutional levels (Botbol, 2010; Carter et al., 2014; Van Veelen et al., 2017).

In the delivery of family-centered care, the child's perspective or focus is not prominent. Children are rarely or never involved in decisions about their care. This results in children's voices not being heard and therefore affects their treatment adherence. Therefore, it is considered necessary to redirect the family-centered care approach to an approach that centers the child's rights to participate in all aspects of health care delivery together with the needs of their families (Coyne et al., 2016).

How to Involve Children in Family-Centered Care?

If the child's participation is to be beneficial for the child's development and recovery, health professionals must put themselves on the same level as the child. This can be achieved by communicating in the child's language, using simple language that the child can understand, and playing games with the child when necessary. Children and adolescents are similar to adults in identifying their needs. Their views should therefore be included in the assessment of the care provided and in care planning (Heimann, 2000). Like adults, children need to feel confident that a health worker is listening to them. This can be demonstrated by paraphrasing what they are saying, looking into their eyes, reflecting by nodding or holding their hands while they speak, and using non-verbal communication skills. This makes them feel valued and respected. Even with a child who does not speak at all, simply asking them about their complaints, even if they do not respond, shows that the child is valued and this can make them trust you and cooperate with you (Majamanda et al., 2015). Regarding the views of the child, Article 12 of the United Nations

Convention on the Rights of the Child states that *'Every child has the right to express his or her views freely, to have his or her views taken into account and to participate in any matter or proceedings concerning him or her*'. This right has not been included in other declarations on children's rights and has been included for the first time in the 'Convention on the Rights of the Child' (UNCRC, 1989).

What happens when children are not involved in Family-Centered Care?

When children are not involved in family-centered care, they can become invisible and ignored. The focus is on the needs of the family and the child may be forgotten in the process. As such children become dependent on their parents for everything, they may not be able to express themselves and develop self-confidence. Children may believe that their parents are in a better position than them to communicate their needs to health professionals, they may think that their opinions cannot be taken into account and therefore they may not trust themselves (Coyne & Gallagher, 2011; Majamanda et al., 2015). Children may not be able to comply with treatment because they do not understand the importance of treatment and think that their parents are forcing them. This may cause them to feel victimized. Therefore, it is important to remember that children are the key point in health care services and that they are the beneficiaries of the services or not passive recipients (Robertson et al., 2014). Giving children the chance to express themselves and explain how they feel helps health professionals to communicate with the child and gain trust. According to the literature, when children are given information they can understand, their self-confidence increases and they are empowered to take a leading role in issues affecting their health, reducing stress, confusion, and misunderstandings and thus reducing children's anxiety (Coyne et al., 2014, 2016). Empowered children can follow and carry out preventive and promotive activities to protect their health. They can adapt to treatment when they are ill and this also reduces the responsibilities of parents as the child is actively involved (Coyne, 2008; Runeson et al., 2002).

Why is Child Participation Important in Family-Centered Care?

Family-centered care mentions that children are involved in their care, but this is not clearly evident and the family is given more importance than the child (Lambert, 2011). In family-centered care, the older child's capacity for independent decision-making and right to privacy are ignored and the child is not actively involved in family-centered care and their needs are not met. To ensure that children's needs are met, it is important to involve and support them at all levels of care depending on their age and stage of development (Moorey, 2010). Child participation includes providing an opportunity for children to voice their concerns, allowing children to do what they can on their own and recognizing children's capacities. It is also important to consult children on issues affecting their health and involve them in decision-making. This can be achieved by communicating directly with the child rather than with parents, informing children about their care and respecting their views. When this happens, a child feels cared for by a health care professional and becomes cooperative. Children's self-esteem is also supported and their overall well-being improves as a result (Majamanda et al., 2015).

During clinical examinations, health professionals interact with parents even when the child is present, giving information only to the parents without involving the child (Bray, 2007). In order for the child to participate effectively in his/her own care, the parent must show advocacy and determination to ensure that the child's voice is heard and his/her needs are met. A child may not be able to communicate directly and effectively with health professionals about their needs and may require a parent to do so on their behalf. If the child's wishes are contrary to the health professionals' plan of care, the parent should confront the conflict and decide what is right for both parties (Taylor, 2006). If a parent sees that their child's wish or alternative to care is reasonable and not accepted by a health professional, they can refer them to another health professional who can understand the child's and parent's point of view and fulfill the child's wish (Majamanda et al., 2015).

Another issue that needs to be taken into account when caring for children is privacy. In a study by Bray (2007), privacy was one of the issues that children expressed a need for during consultations . This was expressed in a child's diary as '*It was a bit awkward (asking* questions) because there were so many people in the room, it would have been easier without them'. Similarly, (Espezel & Canam, 2003) recommend a private, cozy and comfortable assessment space for effective information giving and optimal holistic care for children. These findings remind health professionals to always consider privacy issues when dealing with children during communication and examination. Children are human beings just like adults and should be treated with respect and sensitivity.

As children and families may have different goals, preferences and perspectives, it is important to ensure that a child's voice is heard in terms of family-centered care (Lambert, 2011). It has been reported that children with long-term conditions have different views and priorities about their health and illness than their parents. Asking the parent alone about the child's complaints or progress is not enough to elicit all the subjective data needed. It is therefore important to ask children to describe their feelings and health professionals need to listen to them with interest and attention (Callery et al., 2003; Jutras et al., 2003; Majamanda et al., 2015).

CHILD-CENTERED CARE

Child-centered care puts children at the forefront, placing their interests and opinions at the center of health care practices (Carter & Ford, 2013). Child-centered care recognizes children as the protagonists of their own lives and supports their right to participate/involvement in their own health care (Bray et al., 2014). The concept of child-centered care gained momentum at an ABM workshop with nurse academics in Lund, Sweden in October 2014, and references to child-centered care and child-centered health care in the health literature have become more prominent in shaping child health care (Coyne et al., 2016). Child-centered care advocates that children should be recognized for their right to participate in decisions about health care services. Although

the principle of children's participation is supported by different organizations, the literature reports that children experience barriers to participation in decision-making (Coyne et al., 2014, 2016) and are partially involved in decision-making processes in health care (Coyne, 2008). Observational research has also found that giving information to the parent and not the child often relegates children to a non-participatory status (Tates et al., 2002; Wassmer et al., 2007). Children may be sidelined because parents are the focal point in decisions about children (Coyne et al., 2014). Research shows that children often prefer to be involved in health care interactions, to know what to expect from their care, and to be respected for having a voice in their care and treatment (Hallström et al., 2002b; Runeson et al., 2002). It is also reported that they want to be involved in decisions about their care, procedures and treatment in hospital and feel more prepared and less anxious when they are provided with information and involved in their care (Coyne et al., 2014; Coyne & Gallagher, 2011). Children may feel powerless and marginalized when their preferences for inclusion are not met or are blocked (Coyne, 2008; Runeson et al., 2002). Research with children clearly shows that they are not passive recipients of care and can provide valuable insights into how care should be delivered. Therefore, children's participation in decision-making in health care often depends more on the attitudes of parents and health professionals than on their actual competence (Mårtenson & Fägerskiöld, 2008; Schalkers et al., 2015).

Child-centered care puts children at the forefront, placing their interests and opinions at the center of health care practices, recognizing children as the protagonists in their own lives, and supporting their right to participate in their health care. Child-centered care offers health professionals a more radical way of thinking about how to involve children and families in care, as it sees the child's interests as the starting point in planning and providing care (Ford et al., 2018). The main goal of child-centered care is that children's right to participation and their competence in making decisions about their own lives should be recognized by all. While recognition of children's right to participation and competence in making decisions about their own lives is an integral part of child-centered care, it is considered that linkages in decision-making may limit the dynamic nature and prominence of the child in health care delivery. Child-centered care suggests that the best interests of the child, regardless of age and ability, should be the primary focus of care. It recognizes that children's participation and competence in decisions about their own lives will change over time and will be influenced by the environment, culture, previous positions, and actions of health professionals (Bray et al., 2014; Carter & Ford, 2013).

Why Move to Child-Centered Care?

In pediatric nursing, care differs according to the perspective of health professionals and the culture, values, and attitudes of the society in which they live. For this reason, a philosophy, framework, and care models are generally used while caring for the child. One of these models is the family-centered care model. Research, articles, and books have been published about family-centered care, proving its importance. However, it also highlights the difficulties in implementation. Although family-centered care has been widely adopted by pediatric nurses and is the preferred model in many pediatric units worldwide, the literature shows that implementation remains problematic (Coyne et al., 2016; Foster et al., 2010). In addition, little evidence is reported on the impact and effectiveness of family-centered care for children and families (Coyne et al., 2016; Öztürk & Ayar, 2014; Shields, 2015). Mikkelsen and Frederiksen (2011) *concluded* in a concept analysis that *'the perspective of the sick child is not very salient in the current conceptualization of family-centered care'* and that *'it is a misunderstanding to assume that outcomes are the same for parents and child'*. In the literature, while some sources argue that family-centered care should be valued (Carter, 2008), its antecedents and qualities should be examined (Shields, 2010, 2015) some sources emphasize that family-centered care should be replaced with a model that will guide the care of children not only in the hospital setting but in all areas of health care (J. Smith et al., 2015). In this context, the use of family-centered care in practice may, firstly, cause parents and health professionals to establish an asymmetrical relationship with the child and divert attention away from the child. Secondly, it requires renewed efforts to develop the basic principles of child protection, support, and participation according to the United Nations Convention on the Rights of the Child. Lastly, it may prevent us from strengthening the child's perspective and seeing him/her as an individual with aspirations, representing his/her own experiences, which need to be respected and negotiated (Coyne et al., 2016). *The points where* family-centered care and child-centered care *differ from each other* in terms of basic concepts are given in Table 1.

Table 1. Basic Concepts of Family-Centered Care and Child-Centered Care (Conk et al., 2022)

Basic Concepts	**Family-Centered Care**	**Child-Centered Care**
Partnership and cooperation	Parents are the focal point of the partnership	The child is the key and active individual/actor in the partnership.
Decision making	Parents make the offical decisions.	The child is involved in decisions affecting their care. In line with his/her competence, he/she is defined as an individual with needs and rights to privacy and dignity.
Respect for differens	It is judged by the parents, in the interests of the family.	The child is seen as a social individual/actor with his/her own rights.
Knowledge sharing	Sharing is usually based on parents' views and preferences.	The child is involved and guided by an adult
Care planning	Care is planned around the family as a whole.	Care is planned according to the child's perspective and preferences.
Family and community context	Care is provided in the context of family and community.	Care is provided in the context of family and community.

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Basic Principles of Child-Centered Care

The underlying principles of child-centered care include: a holistic understanding of the child as more than just their health or illness; concern for the overall experience of the child and family; recognition of children and their parents as partners in care; advocacy to coordinate services around the needs of the child and family; and ensuring appropriate transition to adult services. Child-centered care offers health professionals a more radical way of thinking about how to involve children and families in care, as it takes the interests of the child as the starting point in planning and providing care (Coyne, 2015).

The basic principles of child-centered care are seen as encompassing the fundamental principles of the rights to protection, support, and participation in the United Nations Convention on the Rights of the Child. *The protection rights* include the right to be free from harm, neglect, and abuse, fear, pain, and loneliness, as well as from too much medical intervention or refusal of necessary treatment. *Rights to support* include rights to resources such as education and care. *Participation rights* include the child's right to make decisions about themselves, dignity, respect, integrity, non-interference, and the right to speak up and make informed personal decisions. The concepts of age and maturity as expressed in the competence of the child are factors that determine the extent to which the child's views, opinions, needs, preferences, choices, and decisions are met. To support countries in effectively implementing these basic principles, the Council of Europe has developed a Child Participation Assessment Tool (Council of Europe, 2014). Various organizations have produced guidelines for incorporating contract principles into children's hospital care (Clarke & Nicholson, 2007; EACH, 2015; NOBAB, 2023).

Potential Challenges of Child-Centered Care

It is thought that child-centered care will not be less challenging in terms of difficulties encountered in practice compared to family-centered care (Bray et al., 2013). In the study examining children's experiences of clinical care, as they go through a clinical procedure, the following observation by a child participant illustrates some of the tensions encountered when implementing child-centered care.

A 4-year-old girl enters the blood collection room with her family to have blood drawn for the first time. She is wearing the 'magic' local anesthetic cream and appears quiet and anxious as she enters the room. Her father sits in a chair and puts her on his knee and hugs her around the middle. The girl sees the equipment and starts to say 'no, no, no, no' and starts to cry, her father directs her to look at her mother on the other side of the room and hugs her tighter. The health worker says "Don't worry, it will only take a minute" and holds the girl's arm while her father continues to hug her tightly so that she cannot move. The girl cries quite loudly when the butterfly is inserted. The procedure takes about 30 seconds, a band is applied and the girl is released from the embrace. The girl then continues to be upset for several minutes and no one in the room speaks to her directly as she continues to sit on her father's lap and the health professional separates the blood tubes. Her mother then takes out a magazine from her bag and says 'look what I got you' (Bray et al., 2013).

Child-centered care, which advocates prioritizing children's views and interests, can be undermined when others define and decide what is best for the child. In the example above, the child's parents and the health professional decided that it was in the child's best interests to complete the procedure as soon as possible. The child's expressed wishes to 'stop' or 'not start' the procedure were overridden by the adults present and the child's perspective was not sought; the child was given a passive role. The parents' decision to detain them and continue with the procedure was considered. As the child's interests are defined by the parents, who are seen to know and act in the child's interests, it can be argued that this diminishes the child's interests and right to struggle. The child (individual) is still young and has little experience of health care procedures. They are dependent on adults and the systems around them to prioritize their rights and support their ability to participate in health care. They need parents who are knowledgeable and can help them to be actively involved (microsystem), parents who know ways to help their child through a procedure. They need health professionals (exosystem) who have clinical time to spend with them and their parents to talk about what will happen and decide what strategies to use, who can ignore the busy waiting room and challenge the expectation that holding a child for a blood test is an expected and acceptable practice. They need a health service that values long-term outcomes as much as short-term gains and goals. They need a society (macrosystem) that positions children as agents and is empowered to participate in conversations about what happens to them and their best interests (Ford et al., 2018).

Are Child-Centered Care and Family-Centered Care Different or Complementary?

Foster (2015) argues that it is more realistic to lead with the 'family' and that we need to move towards a model of care that is 'family and child-centered care'. This is because parents have a responsibility to care for their children and promote their well-being. However, Ford et al. (2018) criticizes this proposed model for not giving the child a primary position, placing the child's best interests second only to those of the parents. In response to this, he suggests that the concepts of family-centered care and child-centered care should be integrated with each other, as Foster suggests, but suggests that 'family and child-centered care' should be revised as 'child and family-centered care'. In this way, he argues, the child is positioned as primary rather than secondary. Despite widely reported difficulties with the interpretation and implementation of family-centered care in practice, family-centered care is still recommended as the most appropriate model for the care of children. Therefore, the key questions that child-centered care raises are: how does child-centered care differ from the well-established family-centered care model, where exactly is it positioned in relation to family-centered care, and how is child-centered care complementary? It is reported that child-centered care can be an alternative to family-centered care (Coyne et al., 2016; Shields, 2015). Regarding the views of the child,

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Article 12 of the United Nations Convention on the Rights of the Child states that *'Every child has the right to express his or her views freely, to have his or her views taken into account and to participate in any matter or proceeding concerning him or her*'. The right to participation is not included in other declarations on children's rights and was first included in the 'Convention on the Rights of the Child' (UNCRC, 1989). The fundamental goal of child-centered care is that children's right to participation and competence in decisions about their own lives should be recognized by everyone. While recognition of children's right to participation and competence in making decisions about their own lives is an integral part of child-centered care, it is considered that linkages in decision-making may limit the dynamic nature and prominence of the child in health care delivery. Child-centered care suggests that the best interests of the child, regardless of their age and abilities, should be primary in care. It recognizes that children's participation and competence in decisions about their own lives will change over time and will be influenced by the environment, culture, and previous positions and actions of health professionals (Ford et al., 2018).

RESPONSIBILITIES OF THE PEDIATRIC NURSE IN TERMS OF FAMILY-CENTERED CARE AND CHILD-CENTERED CARE

The pediatric nurse should develop a full partnership with a child's family to provide family-centered care and support the family. Furthermore, there should be mutual respect and equal partnership between the pediatric nurse and the family. Utilizing her/his role as an educator, she/he should implement structured educational interventions in family-centered care to raise parental awareness and improve their behavior (Shields & Tanner, 2004). Pediatric nurses should be sensitive to the individual needs of parents and provide the necessary emotional support. It is important that they make a conscious effort to know and understand the family they are working with (Majamanda et al., 2015). At the same time, they should encourage parental involvement in care, explain the disease, treatment and all procedures correctly and clearly, and should not ignore the needs of the parents themselves (Söyünmez & Koç, 2020).

In order to provide child-centered care, the pediatric nurse must first and foremost see the child as an individual and support their right to be involved in their health care. They should develop a full partnership with the child and his/her family in order to provide better care. The pediatric nurse should have a holistic perspective that cares about the experiences of the child and his/her family, adopts them as important stakeholders in health care, and adapts to their needs by not seeing the child only as an illness. Pediatric nurses should protect the rights of the child and raise awareness of the child and the family by using their role as advocates (Conk et al., 2022).

The pediatric nurse must first recognize that child-centered care is not simple and can even be challenging. For example, if the best interest of the child is truly paramount, should a parent's instruction to continue with a routine procedure be accepted, or should the best interest of the child take precedence over the best interests, wishes, and needs of the parent? It is not yet known whether this position positions the pediatric nurse differently from current practice. If we plan to nurse in a child-centered way, does this require more courage and commitment? Can this approach work? There is no guarantee that this conceptual framework will work any better than family-centered care or other models that have been proposed in relation to the care of children in health care. However, in a context where family-centered care fails to adequately involve children in most health services and has a strong predisposition to collaborate primarily with mothers, how we care for children needs to be rethought. There needs to be a greater focus on the rights of the child and their desire for greater participation in health care, acknowledging the centrality of the child and making health care for children more child/person centered (Ford et al., 2018).

CONCLUSION

Whatever name is given to the evolving approach to children's care (child-centered care, child- and family-centered care, or family- and child-centered care), we need to protect children's rights to be active participants and active partners with their parents in their health care. This is not to deny the importance of the child's family, but it is important to remember that they can play a more comprehensive role in their child's life if they so wish. (Achema & Ncama, 2016) in an article on family-centered care mention that the spirit of "*ubuntu*" is central to empathetic and supportive care. Ubuntu is considered a deep-rooted African word that recognizes the connections between people, representing concepts of human interdependence and communalism. Ubuntu is often summarized by statements such as "I exist because we exist". The essence of the concept is that people are not seen as separate from each other. If we integrate this concept into health care, 'ubuntu' is the acceptance that people (children, parents, and professionals) are in relationship/interaction with each other and their environment. This aligns well with the concept of child-centered care, which recognizes both the centrality of the child and the importance of the family, acknowledging *that 'a child becomes a child through his/her family'* (Ford et al., 2018).

Child-centered care has been variously described as an approach, a model, or a way of thinking, and there is still debate about what exactly it entails. Child-centered care could be an alternative to family-centered care, as there is strong evidence in the literature that family-centered care does not work very well in practice and that we are failing to address the problems associated with its implementation. However, attention should be paid to the problems associated with replacing a system that is not working very well with others that are potentially more demanding. It is important to balance child-centered care with family-centered care in the management of sick children to ensure that the needs of children and families are met. More research on the needs of children, using a combination of child- and family-centered methods to directly access the experiences of children and young people is needed. The results will help identify and address potential gaps in education, research, and clinical practice in pediatric nursing and health care.

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