

Foreword

'They looked at my ears, they looked at my throat, they looked at my tummy, but they didn't look at me' (Hubbuck, 2009, p. 158; Jolly, 1981).

June Jolly's¹ profound quote immediately resonated with me and evoked memories of my own experiences as a clinical paediatrician. It reminded me of multiple conversations I have had with sick children over the years, such as when one of my colleagues, referring to a picture on a bed-headboard, asked a five-year-old oncologic patient: *'Who is that kid in the picture?'* He smiled and replied: *'That was me, before I became a Lymphoma'*.

I have routinely used this example to teach younger generations of physicians to acknowledge, at all times, children's perspectives when in hospital. In addition, I have emphasised that the mere presence of illness, as well as the overall hospital experience, can have a significant effect in shaping a child's construction of self-image and the development of hospital-related trauma. Upon diagnosis with a disease requiring hospitalisation, children are taken-away, almost immediately, from everything they cherish and that is familiar to them (e.g., siblings, pets, toys, home, etc). Sick children, and their families, immediately enter a new, scary, uncomfortable, and serious world full of technical and confusing language. In hospital, sick children are often referred to by their bed or room-number, instead of their names. Similarly, names are interchanged with diagnoses; patients are repeatedly called a 'Lymphoma' or any other unfortunate disease. Although all decisions are taken to provide children with vital medical attention, their lived-experience is accompanied by different and unsettling sights, noises, smells, and complex emotions.

It can be hard to be a child in a hospital. Sick children are often daunted and experience hardship during hospitalisation. Hospitals are not usually designed or built with children in-mind. They have sterile walls, bright lamps, noisy equipment and pointy metallic materials. Children in hospital are bound by strict rules; they are not allowed to play or move around (Adams, 2002; Bluebond-Langner, 1978; McKinty, 2013). In addition, they are subjected to multiple blood tests or procedures and have no power or control in the decision-making process, which affects their lived-experience. Although there are some exceptions, children tend to be rarely acknowledged or directly addressed by medical-staff (Hubbuck, 2009; Pérez-Duarte Mendiola, 2022). They find themselves immersed in an environment where they are bound to sit silently or lay-down for days, weeks or months, having to comply with whatever is 'necessary', without understanding the purpose behind it.

Foreword

As a paediatrician, I started searching for evidence-based strategies to shape children’s hospital experiences and prevent hospital-related trauma. This mission guided me to pursue a career in Medical Anthropology in the United Kingdom, where I eventually came across ‘Health Play Specialists’. Globally, these healthcare professionals are also known under multiple names and labels, such as ‘Play Specialists’, ‘Child-Life Specialists’, ‘Child Life Therapists’ or ‘Medic Pedagogic Healthcare Workers’ (Perasso et al., 2021). As my research evolved, I discovered that within this ‘daunting healthcare world’, these professionals introduce ‘Play’ to radically modify the environment which shapes the lived-experience, and overall outcomes, of children and their families. Play Specialists are healthcare workers who focus on delivering psychosocial care to paediatric patients; they “intervene by kneeling or getting physically down to the child’s eye-level and facilitate the introduction of ‘Play’ to collapse hierarchies, fears, and misunderstandings, which will then have a positive impact on self-image and improve their ability to adjust” (Pérez-Duarte Mendiola, 2022, p. 3).

The delivery of ‘Specialised Play’ has an active role in helping sick children, in hospitals and throughout the community, adding value to paediatric-healthcare-delivery. Play Specialists improve the child’s environment and empower them to actively participate in and make choices regarding their care (Perasso et al., 2021; Stewart, 2008). These healthcare workers provide guidance that aims to: (1) increase coping mechanisms during hospital admission and painful/invasive procedures; (2) provide effective communication channels with caregivers; (3) reduce anxiety; (4) arm children with tools to manage diagnosis and treatment; (5) keep developmental regressions to a minimum, promoting self-esteem and independence; (6) provide preparation, during-procedure and/or post-procedural ‘Play’ interventions, enabling children to comprehend the previously lived event; and (7) translate medical terminology for children and their families (Hubbuck, 2009; Perasso et al., 2021; Romito et al., 2021; Stewart, 2008).

The scope of Play Specialists also includes providing orientation for parents, siblings, and other family-members, where applicable. In addition, they have the potential to collect valuable qualitative data for future researchers in this field, as well as provide useful tools, methods and strategies that could be learned and applied by other paediatric healthcare-workers (Brook et al., 2009; Gulyurtlu et al., 2020).

It is our hope that by learning from Play Specialists throughout this handbook, regardless of your role in improving the overall wellbeing of children, we are enabling, empowering and encouraging you to genuinely look at their *ears, throats, tummies* and must importantly... to actually look at THEM.

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ENDNOTE

- ¹ June Jolly was an English Paediatric-nurse and social worker, who modified British paediatric-healthcare in the 1970s and 1980s. Based on her hospital-observations, she published her book: 'The Other Side of Paediatrics: A Guide to the Everyday Care of Sick Children'. She proposed a 'family-centred' model within paediatric-hospitals in order to care for the social and emotional wellbeing of hospitalised children (Hubbuck, 2009; Jolly, 1981; Leach, 2016).