Protecting, providing and participating: Fathers and their children's unplanned hospital admission.

Higham, Sue

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Fathers and their children's unplanned hospital admission

Sue Higham

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ProQuest LLC.
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106 – 1346

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This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree

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Summary

Fathers are being encouraged to be more involved with all aspects of their children's lives and patterns of responsibility for earning income and childcare within families are changing. Yet fathers have been overlooked in previous nursing research into the experiences of the parents of sick children in hospital, leaving nurses wishing to practice family-centred care without an evidence base for their practice with fathers.

In this thesis an investigation is presented into the experiences of fathers of children admitted to general children's wards in a District General Hospital following acute illness or injury. A critical realist ethnographic approach was adopted in a study design incorporating participant observation, interviews with nurses and post-discharge interviews with fathers. Data were analysed through a process of content analysis and interpretation. Interpretation was guided by domain theory, reflecting the understanding that the social world is multidimensional. This enabled the complexity of fathers' experiences and the factors which influence them to be identified.

Whilst fathers were often seen by health care professionals to be marginal to the child's illness, the study showed that many fathers played significant roles in the families' experiences of hospitalisation of a child for acute illness. Fathers could face barriers to involvement in the child's care which mothers did not. Such barriers arose from their own understandings and circumstances, but also from mothers' and nurses' behaviour in addition to institutional processes and routines. Nurses had received no training or education on working with fathers and therefore based their practice on experiential knowledge.

The study indicates the need for changes in nurse education to better prepare nurses to practice family-centred care with 21st century families. It also demonstrates the need for practitioners, institutions and policy makers to take both mothers and fathers into account in the planning and delivery of children's acute in-patient care.

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PART 1

Chapter 1 Introduction and background to the study

INTRODUCTION

In this chapter the personal societal and professional contexts of this thesis are established and the theoretical basis is established. Subsequently, the research aim is set out and the structure of the thesis is explained.

1.1 THE PERSONAL CONTEXT

This thesis forms part of a doctorate in Nursing Science. Interest in its subject- the experiences of fathers during their child's hospital admission for acute illness- arises from my personal experiences as a children's' nurse and lecturer in children's nursing.

I began my career as a qualified children's nurse working on a neonatal surgical unit in a children's hospital. Babies needing surgery in the first few days of life, often within hours of birth, were transferred by ambulance from maternity units over a wide geographical area. The babies were unaccompanied; their mothers were still in need of maternity care which a children's hospital could not provide. Their fathers often arrived on the neonatal unit, shortly after the baby, shocked and confused. A central part of my job, as I saw it then, was enabling fathers to hold, or at least have some physical contact with, their babies for the first time. In doing so I watched men become fathers in front of me. Yet there was no body of nursing knowledge to guide me and there was at the time no scholarship of fatherhood. I acted on instinct and I knew this was a significant moment for them. As a twenty-two year old female without children, I did not realise how significant.

Throughout my clinical career, I worked closely with parents in caring for sick children, conceptualised over the years as involving parents, working in partnership with parents and practising family-centred care.

I have continued to be interested in fathers throughout my career- as a staff nurse and sister in a general children's ward, then through into nurse education. Both

society's expectations of fathers and fathers own expectations have changed in recent decades. Fathers are now and are expected to be actively involved in their children's lives. Yet they remain largely invisible in children's nursing research. I was puzzled both by this invisibility and the perception among some nurses of fathers as problems.

Completing a doctorate in nursing science provided me with the opportunity to begin to address the knowledge deficit which had long concerned me.

1.2 THE SOCIAL CONTEXT

Recent decades have seen significant changes in the structures of families, fatherhood, parental roles and social policy which provide the social context for the study.

1.2.1 Changing families

Hearn (1998) argues that since its foundation, the assumption within the British welfare state has been that the nuclear family with a working father and mother at home was the norm. In reality this was the majority family type for only a short time during the 1950s and 1960s (Hobson and Morgan, 2002). Wars, male death rates and migration have meant that that there have always been families with lone mothers, second marriages and female breadwinners (Williams, 1998). Yet the notion of nuclear family has persisted, with the heterosexual married couple and their biological children described as the ideal (Archard, 2003). However it is also clear that Western societies have undergone rapid change since the middle of the last century, with fundamental changes taking place in men's and women's lives leading to changing gender relations, such as women's increased participation in the workplace and deferred childbearing (Mac an Ghaill and Haywood, 2007).

The British government has acknowledged that increased diversity in the structure, roles and relationships within families has consequences for children and therefore for policy intended to support families, however they are formed (Cabinet Office and Department for Children, Schools and Families, 2008).

Archard (2003) defines family as

"essentially a stable multigenerational association of adults and children serving the principal function of rearing its youthful members" (p69)

Mac an Ghaill and Haywood (2007) argue that "family" is now understood as a negotiated relationship, rather than, as was the case in the past, an institution defined by blood and marriage ties. Therefore membership of a "family" today can be fluid and diverse, with groups of individuals defining themselves as "a family" according to their own criteria.

Consequently children live in an increasing variety of family types. The 2001 Census revealed sixty- five per cent of children living with both their natural parents, eleven per cent in a stepfamily and twenty-three per cent in a lone parent family (Office for National Statistics, 2004) Marriage rates have declined; but whilst forty-two per cent of live births are outside marriage (ONS, 2006), a quarter of children are born to cohabiting couples (Cabinet Office and DCSF, 2008). The overwhelming majority of fathers still live with all their children under eighteen (Burghes *et. al.*, 1997). But there has been an increase in the number of step families; one child in eight will experience living in a step family by the age of sixteen (Ferri and Smith, 1998) and ten per cent of families with dependent children are step-families (Cabinet Office and DCSF, 2008).

Ferri and Smith (1998) found that step fathers were more involved in child care than biological fathers and Pickford (1999) found no difference between married and cohabiting fathers in their involvement or commitment to their children. In reality therefore, family status and structure may make little difference in the stability, commitment to each other and relationships within the family. Whilst family structure and relationships have become more diverse, fathers remain a component of the majority.

However, family change does mean that more men live apart from their children and more men are living with children to whom they are not biological fathers. An individual child may have a biological father, separated from his mother but involved in the child's life, and an unrelated male who assumes the father role in

his or her life. Burghes *et. al.* (1997) use the term "social fathers" to encompass all the variations of the non-biological father-child relationship. Using such a term conveys acknowledgement that a male adult may have a significant relationship and play an important role in a child's life whilst having no biological or legal status.

1.2.2 Changing fatherhoods

Fatherhood is both a biological and socially defined phenomenon. "Father" is both a role and a relationship. In recent decades in Western societies, ways of being men are being questioned and challenged. Fatherhood must be seen within the broader changing context of masculinity, which it both reflects and plays a part in reproducing, at a time when in Western societies previously taken for granted ways of being men are being challenged (Hearn, 2002).

There has been growing academic interest in fatherhood since the 1970s, as part of a burgeoning academic interest in masculinity within gender and family studies, and increasingly within professional literature. In particular there is increasing interest in the role of fathers in their children's lives (Equal Opportunities Commission, 2009), in marked contrast with attitudes from the past. For example, the Platt Report on the care of children in hospital (Central Health Services Council, 1958) was heavily influenced by the work of child psychiatrist John Bowlby. In 1950, Bowlby was commissioned by the World Health Organisation to write a report on the effects of maternal deprivation on infant and child mental health. In his report, he says of mothers:

"What is believed essential for mental health is that an infant and young child should experience a warm, intimate and continuous relationship with his mother" (Bowlby, 1966 p 13)

and of fathers:

"in the young child's eyes father plays second fiddle", "his value as the economic and emotional support of the mother will be assumed" (Bowlby, 1966 p 15)

Whilst Bowlby's ideas modified in later years, and his attachment theory has been refined to encompass a primary attachment to the father and include multiple attachments (Featherstone, 2009), his understanding of the mother -child relationship was highly influential at the time of the founding of the welfare state

(Wetherell, 1997). Along with an early focus on mothers in psychological research, Mac an Ghaill and Haywood (2007) highlight an emphasis on mother-child relationships and the near invisibility of the father in early sociological work on the family.

In his overview of fatherhood research, Lamb (2000) has argued that over decades the defining aspect of fathering has shifted from the provision of moral guidance through breadwinning, sex-role modelling, marital support to nurturance and the emergence of "new fatherhood" in the 1970's. Early fatherhood research focused on father absence (Krampe, 2009), whereas more recently, researchers have explored the effects of fathers' personal characteristics, employment and behaviour on child development (Equal Opportunities Commission, 2007), albeit with a focus on early childhood (Videon, 2005).

Marsiglio and Cohan (2000) argue that the dissolving of earlier norms for fatherhood has created the opportunity for individuals and families to construct their own different father identities. However in constructing these, individuals are influenced by the dominant discourse of what it is to be a good father. Fatherhood practices vary with class, ethnicity, culture and age and that within a child-adult relationship, fathering practices change as the child and father age, develop and experience different circumstances (Palkovitz and Palm, 2009). Much of the research on father involvement has been conducted with middle class, two heterosexual parent families (Burgess, 2008). Williams (2009a) also argues that white working class men and African-Caribbean fathers, who may have different understandings of masculinity and fathering, have been overlooked in fatherhood research. Ferguson and Hogan (2004) have argued that young, unmarried, working class fathers can be invisible to officialdom, or stereotyped or marginalized by professionals as feckless or dangerous, yet in private they found these young men to be active and committed carers for their children.

Currently "involved fathering" is the dominant discourse. Flouri (2005) has identified involved fathering to entail: being there for children; providing for physical needs and providing psychological support and moral guidance. Father

involvement is claimed to be good for children; it leads to higher self-esteem, better friendships, more empathy, better life satisfaction, higher educational achievement, decreased risk of criminality and decreased risk of substance abuse (Layard and Dunn, 2008).

There is some evidence that there is general support in society for involved fathering. For example, participants in Henwood and Proctor's research (2003) with new fathers viewed a good father as present in the home, involved with their children and sensitive to their needs. Warin *et. al.* (1999) also found a clear expectation that fathers should be "involved" in the family although the reality of involvement was tempered by a reluctance of both sexes to surrender traditional roles.

Involved fathering clearly underpins recent policy development, but Featherstone (2009) suggests that policy makers have made claims for "involved fathering" which exceed the subtle and nuanced findings of research. Lamb *et. al.* (1987) caution that increased paternal involvement should not be seen as a universal goal, yet the potential risk that some fathers may pose to some women and children is not acknowledged in policy.

1.2.3 Changing parental roles

The terms "mother" and "father" are now understood, at least within academic fields, as gendered roles rather than biologically determined functions (Mac an Ghaill and Haywood, 2007). However the extent to which this holds true in the general population is open to question. Strongly gendered attitudes towards family roles were revealed by Ferri and Smith (1996) in their analysis of data from the National Child Development Study. A study by MORI for the Equal Opportunities Commission on fathers' needs and expectations at home and work also found widespread acceptance of traditional roles alongside a wide diversity of fathers' roles within families, with couples claiming to make pragmatic decisions relating to child care and work based on earning capacity (Hatter *et. al.*, 2002). More recently researchers for the Equality and Human Rights Commission found that 47per cent

of parents believed that the parent who is paid more should work, regardless of gender whilst 22 per cent disagreed in a national survey (Ellis *et. al.*, 2009).

Research by Warin *et al.* (1999) found the majority of parents and children, but particularly fathers saw providing an income for the family as the central aspect of fathering. Yet many fathers feel they do not spend enough time with their children (Ellis *et. al.*, 2009).

There have also been changes in female work patterns. Dex (2003) argues that the 1.5 earner household (that is, a father who works fulltime and a mother who works part-time) has become the norm, with the greatest change being the increase in the number of mothers of children under five in paid work. For example 50 % of mothers of nine-month-old children are now in paid work (Dex and Ward, 2010), 40% of mothers with young children work part-time and 17% work full time (Cabinet Office and DCSF, 2008). Fathers in dual full time earner households were found to be more likely to share childcare and domestic work and, in some families, shift parenting occurred where fathers were responsible for child care whilst mothers worked and vice versa (Ferri and Smith, 1996). Yet many described work as a welcome escape from family life (Hatter *et. al.,* 2002). Therefore parents of both sexes may experience tension between paid work and family responsibilities.

The government has claimed that most fathers want to be more involved in childcare (Cabinet Office and DCSF, 2008). On average, fathers in two-parent families carry out 25% of childcare during the working week with this rising to one third at weekends (EOC, 2003) and 21% of fathers of children under five years are *solely* responsible for child care at some time during the working week (EHRC, 2009). Yet the Fatherhood Institute argues that fathers seeking to be more involved in childcare face obstructions (Fatherhood Institute, 2011). Social structures have an influence on individual decisions; better paid fathers have more freedom in balancing the provider role with other aspects of fathering than those who have to work long hours to provide sufficient income (Marsiglio and Cohan, 2000).

Fathers' own beliefs and commitment are also important factors determining the level of involvement with children (Gaunt, 2008) and these are influenced by age,

race ,views of gender, socio-economic circumstances and relationships (Marsiglio and Cohan, 2000). For example, whilst Hatter *et. al.* (2002) found that twenty-five per cent of fathers thought mothers were the "natural" carers of young children, fifty-per cent felt that fathers and mothers were equally capable.

It has been argued that a further key factor influencing the extent of fathers' involvement is maternal gatekeeping. This is the controversial concept that mothers regulate fathers' involvement through their own supportive or resistant behaviour (Allen and Hawkins, 1999). Such gatekeeping may not be conscious or intentional (Gaunt, 2008), and is in turn influenced by the mother's own beliefs and attitudes particularly in relation to gender role and beliefs about fathers (Cannon *et. al.,* 2008). Maternal gatekeeping was evident in Henwood and Proctor's study (2003) of new fathers where some men felt they were less involved in decision-making than they wanted to be or felt they had to ask mothers' permission to be involved in baby care. This highlights the point that involved fathering requires mothers to "move over" to make space for them.

Evidence for father involvement in the care of sick children is contradictory. Burghes *et. al.* (1997) claim it remains largely the mother's responsibility whilst Burgess and Ruxton (1996) found that half of fathers in dual earner households shared the care of sick children equally. However, caring for sick children at home was seen as a as a key maternal role with great symbolic significance for their adequacy as mothers by working women (Cunningham- Burley *et. al.*, 2006), so mothers may be very reluctant to surrender this to men, adopting gate-keeping behaviour to preserve it as their own.

Therefore fathers' involvement in the care of their children in hospital will be influenced by the broader context of their normal family lives, including working patterns, their usual levels of involvement with their children and maternal gatekeeping behaviour in everyday life and in relation to the child's hospitalisation.

1.2.4 Changing policy

In the past, men were largely disregarded in social policy, except with regard to their roles as workers and citizens (Williams, 1998). Policy concern with fathers

emerged in the 1980's initially in relation to ensuring that fathers taking financial responsibility for their children (Hobson and Morgan, 2002) and concern for the negative effects of absent fathers on children and families (Lewis, 2002). When it came to power, Blair's Labour government adopted a clear and consistent emphasis on the importance of families and parenting, and more latterly fathers' importance to their children's welfare. Government activity has included setting up organisations to act as centres of expertise on parenting, policy initiatives to support families and legislation. These include:

- The National Family and Parenting Institute (now the Family and Parenting Institute) was set up to act as the "leading centre of expertise on families and parenting in the UK" (Family and Parenting Institute, 2008).
- Financial support to Fathers Direct, now the Fatherhood Institute,-the "UK's fatherhood think tank" (Fatherhood Institute, 2008).
- Establishing The National Academy for Parenting Practitioners to train practitioners to support parents (National Academy for Parenting Practitioners, 2009).

Policy initiatives include:

- Every Child Matters (Department for Education and Science, 2003)
- the National Service Framework for Children, Young People and Maternity Services (Department of Health, 2004)
- "Every Parent Matters" (DfES, 2007).

Every Child Matters set out how services for children and families should be reformed and integrated to support children and parents and the NSF set out how health and social care services should operate in a family-centred way, emphasising that "parents" means both mothers and fathers.

In addition to the EU Working Hours Directive, legislation intended to support working parents in meeting their responsibilities for children and achieve a better balance between work and family life has been introduced. The right for each parent to thirteen weeks unpaid parental leave for each child under 5 was

introduced by the Employment Relations Act of 1999 (The Stationery Office, 1999). The time off can be taken to spend more time with a child and for childcare. Paid paternity leave, extended maternity and adoption pay and the right for parents of young children to ask for flexible working(extended to children aged under 16 years from April 2009), were introduced in the Work and Families Act of 2006 (The Stationery Office, 2006).

The extent to which policy and legislation have had an impact on mothers' and fathers' decisions is open to question however. Hatter *et. al.* (2002) found most men were unaware of rights to parental leave or their employers' family friendly policies, although they expected ad-hoc flexibility for family emergencies from their employers. Consequently a relatively small number of men have taken up parental leave despite expressing a desire to be more involved in child care. Whilst Dermott (2001) argues that this is because parental leave is unpaid, it may also be that organisational cultures prioritise men's work identity over family commitments, meaning that men are wary of employers' and colleagues perceptions of their commitment to work if they make use of parental leave.

These measures clearly demonstrate recognition that not just women are and should be responsible for children's up-bringing; fathers should be "involved". The message from recent policy developments such as "Every Parent Matters" is that families need fathers and that children benefit socially, emotionally and intellectually if their fathers are engaged from an early stage in their lives and the services children use (Department for Education and Skills, 2007), recently re-iterated in the Child Health Strategy (Department of Health and Department for Children, Schools and Families, 2009). Thus policy reforms are focused on a child welfare agenda rather than intended to address broader issues of gender equality (Featherstone, 2009).

Daniel *et. al.* (2005) argue that use of the gender neutral term "parent" is problematic because it ignores the gendered societal context in which fathering and mothering takes place. Similarly, Burgess and Ruxton (1996) have argued that adoption of the gender neutral term "parent" in policy and professional literature,

whilst well-intentioned, has not resulted in greater recognition of fathers' needs. This would seem to be echoed in a statement by the then Minister for Children, Young People and Families that "too often when we talk about engaging parents we actually only engage mothers" (Hughes, 2006). The government itself also recognised that use of "parent" could have the effect of excluding fathers, because fathers, reinforced by the ingrained approaches and practices of workers (HM Treasury and DfES, 2007) perceive the word to mean mothers.

The importance of fathers to children has been specifically identified in some aspects of policy. For example, the DfES emphasised that fathers matter to children and public services should recognise this and seek to engage them (DfES, 2004). The Child Health Strategy (Department of Health, 2009), developed with input from the Fatherhood Institute, asserted the significant benefits to children of paternal involvement in their lives and the Department for Children, Schools and Families launched a "Think Fathers" campaign to encourage public services to be more inclusive of fathers (Think Fathers, 2008).

Thus there has been clear support from central government in both policy and legislation for fathers to be more involved in all aspects of their children's lives, yet in reality, fathers' involvement in decision-making and service use come down to the social and employment circumstances of individual families, maternal gatekeeping and relationships between individual men and individual practitioners.

1.3 THE PROFESSIONAL CONTEXT

Children's nurses are expected to practise family- centred care, a social construct explored in depth in chapter 2. The focus of this section is on the realities of how health and social care workers practice with fathers .

There is some evidence that fathers are marginalised by health services for children, albeit unintentionally. In 1981, Kerr and McKee argued that health staff assumed that because they were rarely seen in clinics, they had little involvement at home, whereas in reality fathers were active carers for their children (Kerr and

McKee, 1981). The relative absence of fathers from child-health related settings such as child health clinics was noted by Lewis and O'Brien (1987).

Edwards (1998) has argued that health and social care workers experience ambivalence in working with fathers. She found workers identified lack of male partner support as a major problem for their female clients, whilst being unable themselves to include men in their activities unless they were the sole carers of their children. Workers would make very positive comments about men who showed an interest in their children and joke with women that their partners were "well-trained" (Edwards, 1998). Marsiglio and Cohan (2000) argue that men who co-parent their children are often treated as heroic by friends and family, whilst what they do would not be considered noteworthy if done by a mother. Health care professionals may adopt a similar position.

Health and social care practitioners tend to consider a man a father only when he is in a relationship with the mother and ignore him when not (Taylor and Daniel, 2000). Furthermore, Burgess (2008) argues that practitioners in children's services commonly fail to identify important males in children's lives and their relationships with the child, particularly when the father is living in another household. Towers and Swift's research (2006) into the experiences of fathers of young children with learning disabilities identified that despite being highly involved in their children's lives, some fathers felt marginalised, left out of decision making and sometimes were made to feel unwelcome at meetings. Young fathers in particular fear and sometimes experience negative attitudes from maternity staff, as do young mothers, (DCSF and DH, 2009). It is possible therefore some fathers feel excluded or undermined in relation to their child's healthcare, respond by absenting themselves from involvement and are then criticised by health and social care workers as uninvolved or unsupportive.

The Department for Children, Families and Schools commissioned research into how fathers could be better supported through policy which identified that recognition of fathers across policy was patchy and that father inclusive practice was not seen as mainstream in family services (Page *et. al.,* 2008). They found a

lack of training among practitioners and managers in family services was a barrier to effective engagement with fathers and that health services were not engaging fathers sufficiently in the early stages of fatherhood around pregnancy and birth (Page *et. al.,* 2008). It would seem that the guidance on engaging fathers for schools (DfES, 2004), midwives (Fathers Direct, 2007; DCSF and DH, 2009) and early years workers (Children in Wales, 2008) is not yet having an impact on practice.

Under the Equality Act of 2010 all public service providers to ensure that services meet the needs of both sexes and ensure that no service users are at a disadvantage on the grounds of gender. In order to do this, service providers need clear evidence of the needs of, and take up of their services, by both sexes.

As yet, there is no specific guidance for children's nurses on working with fathers. A recent children's nursing textbook has four chapters about different aspects of working with families, all of which use the term parent, with no acknowledgement that there might be differences between mothers and fathers. In the index there are entries under parent(al), under mother/maternal and none under father/paternal (Glasper and Richardson, 2006).

Whilst not directly concerned with children's nursing, many of the issues identified by Page *et. al.* (2008) apply to children's nursing. Of particular significance, as the children's nursing workforce is approximately ninety-five per cent female (Robinson *et. al.,* 2006), is their finding that the predominantly female workforce, especially in early years provision, led fathers to believe that services were not for them (Page *et. al.* 2008).

1.4 THE RATIONALE AND AIM OF THE STUDY

A significant body of scholarship on fatherhood has developed in the last twenty years yet this knowledge does not seem to have penetrated into children's nursing's body of knowledge. Recent policy developments support father involvement in children's lives and practitioners in early years, education, social care and health services are encouraged to promote father involvement. Public services now have a gender equality duty and the Equality Act (2010) requires them

to increase equality of opportunity for everyone and to take steps to meet their needs. It is not possible to do this unless one has an understanding of people's own perspectives on their experiences.

My experience as a lecturer, shared by Jolley (2008), is that children's nurses sometimes present fathers as problems because they are "difficult" or "aggressive", whilst not recognising that their own attitudes or communication skills (or lack of) may contribute to such behaviour, suggesting that children's nurses do need improved preparation to work with fathers.

As a first step, children's nurses need to understand both fathers' and nurses' perspectives on fathers' experiences when their child is admitted to hospital in order to practice with fathers in an informed way, not on instinct. My particular interest was in the everyday unplanned admission for acute illness. My research questions were:

What do fathers do during their child's stay in hospital, including on the ward and in life outside hospital, and what determines this?

What determines their level of involvement in care and decision-making, how and why?

How do nurses and fathers relate to and understand one another?

How are partnerships between fathers and nurses constructed and expressed?

The first stage towards this improvement should be an increased understanding of fathers' experiences during their child's health care.

1.5 THE THEORETICAL BASIS OF THE STUDY

My study was underpinned by the critical realist understanding of society developed by Bhaskar (1989). Within critical realism, three levels of reality are identified: the empirical (that which is experienced), the actual (all phenomena, whether experienced or not) and causal reality –the mechanisms which generate phenomena. A critical realist stance in social science sees human action as enabled

and constrained by social structures which can in turn be transformed by this action and that society exists as both the context for and outcome of human action (Bhaskar, 1989). Thus society is not fixed and social entities such as families and fatherhood can change, as discussed earlier in section 1.2.

Within critical realism, the social world is seen as comprising of numerous interconnecting systems (Houston, 2001) and society is relational, made up of the relationships between individuals and groups and the structures which govern them (Collier, 1994). Therefore in order to understand fathers' experiences in hospital, one must have a general understanding of the positions of men, parents, and particularly fathers, and nurses in society in general, in the family and within the social milieu of the children's wards. Also one must understand the *particular* circumstances of the individual. A father's experiences when his child in hospital cannot be fully understood without an appreciation of his usual circumstances- such as his role in the family, his work situation, his relationship with both the child and the child's mother, and his own wishes, values and psyche.

Therefore an ethnographic research design has been used. This involved participant observation on two children's wards and interviews with fathers and nurses in seeking to explore and understand fathers' experiences when their child is in hospital.

1.6 THE STRUCTURE OF THE THESIS

The thesis is presented in three parts. Part 1 comprises this introduction and context as chapter 1.

Part 2 comprises a literature review (chapter 2) in which current knowledge in relation to family-centred care and fathers' experiences of their children's health care is evaluated and chapter 3 in which a methodological account of the research process including data generation and analysis is given.

The introduction to Part 3 justifies the structure of the findings into chapters 4, 5, 6, 7, and 8, each focused on a different one of the five domains of social life derived by Houston (2010) from Layder's domain theory (Layder, 2006). Within Layder's

domain theory, the social world is seen as consisting of four interwoven domains, which encompass, the psychobiographical, social interactions, social settings (which are the institutions within which interactions occur) and the contextual domain which includes cultural, economic and political factors. Chapter 9 provides a Discussion including critical reflection on new insights from the study in relation to current knowledge and a reflexive account on the study. The conclusion forms Chapter 10.

PART 2

CHAPTER 2 Literature review

2.1 INTRODUCTION

In the previous chapter, evidence for changing patterns of family life and resulting greater involvement of fathers in their children's lives in the United Kingdom was explored as the current context for this study. In this chapter, the current state of knowledge about fathers' experiences is established through an appraisal of earlier research and scholarship.

The functions of a literature review are to place a piece of research in its historical context, establish what work has been done and identify areas where further research is required (Hart, 1998). Therefore this literature review starts with an historical overview of the development of family-centred care, leading on to a critical evaluation of the current evidence concerning fathers' experiences of their child's health care through a review of policy, theoretical and empirical work.

2.2 AIM

Clear questions enable a focused review of the literature and in order to support and inform the current study, this literature review has been undertaken to answer the following questions:

What does family-centred care mean and how is it practised in relation to fathers?

What do we know about fathers' experiences of their children's health care, illness and hospitalisation?

2.3 SEARCH STRATEGY

A literature review is an essential part of the research process, forming the foundation of the project (Hart, 1998) and therefore a methodical and rigorous approach to literature searching is imperative (Aveyard, 2007). Literature searching was undertaken using the terms "parental involvement", "parental participation" "partnership with parents" and "family-centred care" and the databases BNI,

CINAHL and Pubmed. No date limits were imposed on this initial search, but the search was restricted to material published in English. A genealogical approach was also used, whereby further literature was identified from the reference lists of identified articles and hand searching of key journals was also undertaken. Whittemore and Knafl (2005) argue that the inclusion of diverse data sources can enhance an holistic understanding of a topic, therefore qualitative and quantitative research from a range of academic fields has been included in this review. Research concerning parents in neonatal and paediatric intensive care units was excluded because these parents face particular challenges, similarly articles specifically concerning technology dependent, chronically ill children, terminally ill children and children undergoing day surgery were also excluded. Seventeen articles, three PhD theses and a book were identified which reported original research conducted in the United Kingdom on topics related to the review questions. In order to identify unpublished research, a search of the EThOS database (the British Library electronic theses online service) was undertaken which revealed no further relevant theses, along with a search of the Royal College of Nursing's Steinberg collection of nursing Master's and doctoral theses.

However it became evident from an initial reading of the literature that fathers of children in hospital barely featured in this body of work. Therefore in order to answer both questions and meet the aim of this review, a second literature search was undertaken using the terms "fathers of children in hospital" and "fathers and healthcare", using the databases CINAHL, Medline and BNI, limited to articles published in English since 1999, but not restricted to British settings or journals. Again a genealogical approach was also used to trace further literature. This second literature search revealed many articles relating to men's transition to fatherhood, experiences of maternity services and as fathers of infants on neonatal units which have not been considered in this review, nor have those involving bereaved fathers. Three papers were identified which examined fathers of children in acute settings, in addition to those identified in the first search which mention fathers as part of projects on parents, as well as four relating to children's healthcare in general, seventeen relating to chronic illness (either specific conditions or chronic illness in

general) and ten relating to fathers of children with cancer. A search of the EThOS database revealed no relevant theses.

Scrutiny of all the identified literature revealed little crossover between that found in the first search and that found from the second search. Therefore for the purpose of clarity, this literature review is presented in two parts, with part one concerned with the literature on nurses, families and family centred care and part two concerned with fathers' experiences of their child's healthcare and illness. A synthesis of current understanding from these two bodies of literature is presented in the conclusion.

2.4 PART 1 NURSES, FAMILIES AND HOSPITALS

2.4.1 The meaning and origins of family centred care

Family-centred care is widely held as the cornerstone of children's nursing practice, within the UK and elsewhere, yet it is consistently identified as an ill-defined concept, for example Darbyshire (1994), Hutchfield (1999), Franck and Callery (2004). The origins and meaning of family -centred care in the United States of America are different from in the UK. In the U.S.A, the notion of family centred care developed in relation to the ongoing care in the community of children with enduring needs within a commercial market-oriented healthcare system. Also, currently the applicability of the concept of family centred care to all health care settings and all patients is emphasised in the U.S.A. (Institute for Family-Centered Care, 2009), whereas in the UK it's use is largely restricted to children's health care. Smith *et. al.* (2002) argue that the philosophical underpinnings and approaches to family-centred care are fundamentally different in the USA and UK. This is not acknowledged in much of the literature on the topic in which authors use British and American literature interchangeably. This may explain some of the confusion identified by among others, Lambert (2011) and Shields (2010).

The discussion in this chapter is premised on the concept of family-centred care as used in the U.K. where Smith *et. al.* (2002) have defined family-centred care as:

"the professional support of the child and family through a process of involvement, participation and partnership underpinned by empowerment and negotiation" p22

Very recently a new terminology has begun to emerge in policy and literature in the U.K., - "child and family centred care" (e.g. in the National Service Framework for Children, Young People and Maternity Services (Department of Health, 2004) and Smith and Coleman (2010), reflecting the influence of both the children's rights agenda and consumerism on health care policy. "Child and family centred care" therefore incorporates the notion that children are active participants with their parents and nurses in negotiation and decision making in health care (Coleman, 2010), although this term is yet to be widely used in the literature.

It is possible to trace the historical developments which led to the development of family -centred care in relation to children in hospital within the U.K. Jolley (2011) argues that in the late 19th Century, nurses caring for children showed an understanding of children's psycho-social needs that was lost in the early decades of the 20th Century when a pre-occupation with science and professionalism replaced an earlier focus on love and care.

There is consensus among child health care professionals that the Platt Report (Central Health Services Committee, 1958) started a process of initially slow but inexorable change in the way that children are cared for in hospital, as recognition developed of the trauma caused by separation of the child from the mother (Jolley, 2008, Davies 2010). However there is some evidence to suggest that the commonly held view, that prior to this report children were separated completely from their children in hospital, is inaccurate. Lindsay (2003), for example, cites examples of some enlightened hospitals allowing parental visits to children before the Platt Report was published. There are examples in the literature suggesting this is the case. For example, in 1952, a paediatrician and ward sister described an experiment in which *mothers* were encouraged to visit for an hour every evening and participate in care (Moncrieff and Walton, 1952) and in 1958 Craig and McKay identified the benefits of a mother and baby unit in which mothers were resident and carried out day-to-day care of their sick babies (Craig and McKay, 1958).

However, publication of the Platt Report is widely recognised as a key turning point. Sir Harry Platt and the parliamentary select committee on the welfare of children in hospital he chaired were heavily influenced by Bowlby's psycho-analytical ideas about the negative effects on hospitalised children of separation from their *mothers* (Central Health Services Committee, 1958). This led the committee to recommend that parents should have unrestricted access to their children in hospital and admission of the *mother* with the child should be encouraged particularly for the under-fives (CHSC, 1958). In a published extract from the evidence submitted by the British Paediatric Association's evidence to Platt (Lightwood *et. al.* 1959), it is clear that paediatricians thought that *parents* should be able to visit, whilst *mothers* should be able to stay overnight. It is also important to recognise that Platt's much cited recommendations referred to young children undergoing planned admissions usually for surgery, even though these accounted for a minority of childhood hospital admissions as Stacey *et. al.* (1970) pointed out.

Robertson collaborated with Bowlby and went on to campaign to raise public and professional awareness of the damaging effects of such separation of child *and mother* through hospitalisation (Alsop Shields and Mohay, 2001) and the reassurance provided to the child in a stressful situation by presence of an attachment figure (Priddis and Shields 2011). The campaign eventually led to the founding – by a group of women- of the consumer movement the "National Association for the Welfare of Children in Hospital" (later to become Action for Sick Children), which lobbied for change in children's hospital care (Stacey *et. al.,* 1970*;* Lindsay, 2003). Thus family centred care as practiced today has its origins in both attachment theory and consumerism.

The emphasis in professional literature on parental presence from this period is very firmly on *mothers* being the resident parent and performing what are described as mothering tasks, such as providing comfort, entertainment and meeting hygiene and nutritional needs (Craig and McKay, 1958; Brain and Maclay, 1968). However, these early, brief, descriptive papers, predominantly written by doctors, do show an awareness of the impact of a child's hospitalisation on other

family members (Moncrief and Watson, 1952; Craig and McKay, 1958), albeit reflecting the gender ideologies of their time.

Changes to patterns of parental residence in hospital were slow and some early lay and professional responses were sceptical. Meadow (1964) reported an investigation into whether *mothers* wanted to stay with their child, reporting that only 44 per cent did, with many citing their need to care for their husbands as a reason why they could not stay with the child. Thus one might argue that fathers were seen by some as a barrier to maternal residence in hospital providing further evidence of the influence of gendered role expectations on parental decisions and experiences. Brain and Maclay (1968) found only 20% of *mothers* agreed to take part in their clinical trial in which mothers accompanied children admitted for tonsillectomy. A key finding of this study was that although accompanied children showed reduced incidence of infection and less behavioural disturbance and 85% of resident mothers were satisfied, nursing staff preferred children to be admitted on their own, finding some mothers "difficult". This notion of "difficult" mothers recurs in later research in a different guise (e.g. Stacey *et. al.* 1970 and see section 2.4.3). The finding demonstrates that nurses were yet to develop a child-centred view of hospitalisation.

Stacey *et. al.* (1970) investigated the experiences of children and parents in hospital during the mid-1960s, finding that implementation of Platt's recommendations was dependent on the commitment to them of individual doctors and nurses with the authority to implement change. Their focus was on mothers and their research reveals how attitudes to children have changed in the decades since their research was carried out. The attitudes of other family members were highly influential on a mother's decision whether to stay in hospital or not. Mothers who had other commitments -such as work and other children, were likely to give a lower priority to staying in hospital with the sick child than to these other commitments. Thus at this time maternal presence with the sick child was seen as discretionary. Stacey *et. al.* (1970) concluded that parental presence in hospital with their children had social implications- for hospital staff and for families that had not been recognised. This team returned to the topic again in the 1970s (Hall and Stacey, 1979),

revealing that the majority of parents (mothers) present on wards had little to do with nurses, believed nurses to be always busy and the sometimes strained relationships between mothers and nurses had the effect of discouraging mothers from spending long periods in hospital.

By 1983, Thornes, using the term parent but meaning mother, found in a national survey that half of wards admitting children were still restricting *parental* access and accommodation for parents was limited (Thornes, 1983). Webb *et. al.* (1985) distinguished between "care-by-parent" units where parents were encouraged to visit freely and assist in care if they wanted and other wards. They found that with active staff encouragement sixty per cent of children were accompanied by a parent. They also surveyed staff and parents views as to which aspects of care parents could and should participate in (Webb *et. al.,* 1985), demonstrating the acceptability at this time of the notion that parents could undertake nursing care, in contrast to earlier views. Sainsbury *et. al.* (1986), whilst acknowledging that parental presence had become widespread, argued that parents in hospital could become bored, lazy, threatening or resentful of nurses. Their solution was to adopt a "care-by-parent" strategy on a general paediatric ward, rather than on a special unit, under which parents were taught to perform some of the less technical aspects of nursing care (such as taking temperatures and maintaining fluid charts) under close nursing supervision, in addition to normal childcare (Sainsbury *et. al.,* 1986). In this study, nurses acted as gatekeepers to the scheme in terms of assessing both child and parent's (i.e. mother's) suitability (Sainsbury *et. al.,* 1986), thus clearly retaining power and control. This also demonstrates that at this stage, parents were not yet seen as having a right, or even a duty to participate in care.

The work of Webb *et. al.* (1985) and Sainsbury *et. al.* (1986) demonstrates that thinking about parents in hospital had developed beyond presence to exploring roles. "Care by parent" was taken further by Evans (1994) who described a small group of mothers of children on an oncology unit being taught how to administer intravenous antibiotics to their children. Although this is a flawed study as the mothers were interviewed by the member of the unit's staff responsible for the education programme they followed, it does demonstrate that some professionals

at this time saw no boundaries as to what could be expected of parents. By the time of Casey's investigation into factors influencing family involvement in care in 1995, analysis of nursing records indicated that eighty-five per cent of children were receiving care from a family member, and for twenty per cent, this included complex care activities such as tracheostomy care or intravenous drugs (Casey, 1995), although the validity of these findings rests on the accuracy of the nursing records. This study reveals how "care by parent" had become part of normal practice and was no longer restricted to designated units.

A key conceptual advance was the development of the partnership model by Casey during the late 1980's. The Partnership Model is based on the belief that:

"the care of children, well or sick, is best carried out by their families, with varying degrees of assistance from members of a suitably qualified health care team whenever necessary" (Casey, 1988 p.9).

The model is flexible and the nurse is expected to adapt their role according to the needs of the child and family. Care is seen as comprising of three elements- self-care, family care and nursing care; who performs which element of care is negotiated between child, family (parents and other significant carers) and nurse with no externally imposed boundaries (Casey, 1988). Casey's model clearly represented a shift in thinking about families, with parents seen as central to their child's care in hospital, although Casey (1995) later recognised that her model is a practice ideal rather than a representation of actual practice.

Nevertheless her work has been highly influential in children's nursing practice and education. Indeed Coyne and Cowley (2007) have argued that partnership caring has become such a dominant discourse in children's nursing thinking that not espousing it could be seen as unprofessional practice, although they found that nurses struggled to implement it in practice.

Further development in the conceptualisation of parents in hospital is demonstrated by Callery and Smith's (1991) investigation into negotiation between nurses and parents. They found that although parents were expected to be extensively involved in their children's care, there was confusion as to the extent of this involvement, arguing therefore that negotiation between nurses and parents

would reduce confusion, uncertainty and conflict. Their investigation into whether nurses did negotiate roles in practice revealed a correlation between greater negotiation and increasing seniority of the nurse (Callery and Smith, 1991), a finding echoed later by Casey (1995) and Kawik (1996).

Hutchfield (1999) has argued that understanding of family-centred care has developed from a series of pre-cursors, which starts with parental presence, progressing through involvement, participation and partnership to family centred-care. If this is so one would expect to identify a chronological sequence in the use of these terms in the literature yet this is not the case. Smith *et. al.* (2002) contend that family-centred care is a composite of these concepts. They have developed a model which describes a continuum of family-centred care in which the nurse responds appropriately to the child and family's needs in any given clinical situation, so care may be nurse-led with minimal parental involvement or completely parent led with the nurse contributing as needed or anywhere in between these two end points and still be family-centred. It may be appropriate for care to shift in either direction along the continuum according to the circumstances; there is not a set goal (Smith *et. al.* 2002).

This overview of the historical literature demonstrates that, whilst practice in relation to parental presence with children in hospital was more diverse in the first half of the 20th century than is sometimes portrayed (van Horst and van der Veer 2009), the Platt Report was the major catalyst for change in the U.K. Changes in the U.K. were mirrored elsewhere in the world (Jolley and Shields, 2009), and other pioneers also sought to bring about change(van Horst and van der Veer 2009), leading to the formulation of the concept of family-centred care. Family-centred care can therefore be seen as having its origins in the work on child-mother separation initiated by Bowlby and Robertson with much of the early work focusing on mothers. Kendall and Tallon (2011) contest this view, arguing that family-centred care has intellectual roots more diverse than attachment theory. However, the overwhelming weight of academic opinion is that attachment theory and concern for the effects of child-mother separation were the focus of scientific debate from which family-centred care arose.

Thornes' (1983), Webb *et. al.*'s (1985) and Sainsbury *et. al.*'s (1986) work is notable for the use of the term "parent" in contrast to the earlier "mother", even though in Webb *et. al.*'s case, 47 of the 48 resident parents were mothers. This usage has continued in much of the later research until very recently. Darbyshire (1994) argued that *"the hospital as an organization helped to shape the concept of 'parent' in such a way that this became synonymous with mother"* (p47). So questions arise from the historical literature as to whether children's nurses have taken "parents" to mean mothers and as to what place there is for fathers in family-centred care.

2.4.2 A critique of family- centred care

Since its adoption in to health policy, research into different aspects of family-centred care has continued but Franck and Callery (2004) have argued that the research is largely descriptive so that the family-centred care approach has not been evaluated and remains untested. Foster *et. al.* (2010) concluded from their literature review that there was no empirical evidence that family-centred care either works or makes a difference. They also identified that both parents and health care professionals experience anxiety, conflict, dissatisfaction, power struggles and conflict (Foster *et. al.* 2010*)*. Lambert (2011) has highlighted confusion of terminology and ineffective communication as continuing problems in the implementation of family-centred care. Shields (2010) has challenged children's nurses to either find the evidence that family centred care works, discover how to make it work or abandon the concept and argued that hospital managers have come to see parents as pairs of hands for basic child care (Shields, 2011).

Mikkelsen and Frederiksen (2011) contend that family-centred care has been built on a narrow understanding of the family based primarily on mothers' views. Lambert *et. al.* (2008) have argued that the child and family have come to be considered as a single entity, unlike in Casey's model from 1988 which clearly delineated child, family and nurse (Casey, 1988), and this has led to the loss of focus on the child. Similarly Söderbäck *et. al.* (2011) have argued for:

" a child-centred approach which incorporates the rights of the child to participate in all aspects of healthcare delivery in conjunction with the need of their family" p 104.

Davies (2010) has called for more collaborative research with children and young people on their perspectives and experiences of child and family centred care.

Having thus traced the historical development of family centred care as a concept, the more recent evidence on the reality of family centred care is now explored.

2.4.3 The practice and experience of family centred care

This section of the literature review focuses on the British literature published since 1991 when family- centred care was first recognised in UK health policy (Department of Health, 1991), as the focus of research changed at that time from whether parents should be present with their children in hospital to accepting parental presence and seeking to develop an understanding of parents' experiences. The literature considered here explores parents' experiences, views and expectations of their experience, nurses' experiences and expectations of working with parents and to a far lesser extent, the views of children and young people.

Table 2.1 provides a summary of the aims, participants, research approach and key findings of each of the British studies since 1991 included in this review and shows that all but three used qualitative approaches. The majority are small scale qualitative projects although there is one international quantitative study, one further quantitative study and one intervention study. Note that in the table the word "parent" is used when authors have not specified the gender of participants. In addition to the literature in Table 2.1, there are a number of systematic literature reviews on the topics of family -centred care, nurse - parent negotiation and partnership which are included in this review. The limited research with children does not address parental involvement in care, with the exception of Coyne and Cowley (2007), but the children and young people's views of their overall hospital experience (e.g. Battrick and Glasper, 2004) or their involvement in decision making (e.g. Runesin *et. al.* 2002), so it has not been included in this review. It has not been possible to locate any research which has examined children and young people's views of parental involvement in care exclusively and

although this was an element of Coyne and Cowley's research (2007) it is not reported in the depth or detail required for appraisal.

Before designing the study and undertaking data collection, thirteen research papers published between 1991 and 2007 were identified as addressing parents' experiences whilst their children were in hospital, reporting nine different research projects, the majority of which are small-scale studies using convenience samples (e.g. Neill, 1996). These studies address different elements of family-centred care although that term is not consistently used within them. Some recurring themes are evident across these papers: being there for the child; parents and nurses as co-workers; relationships between parents and nurses and negotiation of roles. One further paper describes a quasi-experimental pre/post intervention study.

The literature identified was subjected to a thematic analysis, from which the following themes were identified: being there; parents and nurses as co-workers; relationships between parents and nurses and negotiation.

Table 2.1 Overview of British research on parents' experiences in hospital

Author and date	Aims	Research approach	Setting	Participants	Key findings
Darbyshire 1994	To examine lived experiences of parents of hospitalised children and nurses and examine relationships between them	Phenomenology and grounded theory, participant observation and interview	Children's hospital	26 mothers, 4 fathers 12 nurses	Resident parents experience transition process learning to "parent in public" Parents' participation increased over time Nurse-parent relationship both static and dynamic
Casey 1995	To discover extent of families' involvement in children's care and identify factors which influence this	Quantitative retrospective analysis of nursing notes and structured interviews with nurses	2x children's hospitals	Nurses + records of 243 children	85% children receiving some care from a family member Involvement influenced by family factors and matters relating to the child's illness
Coyne 1995	To identify the main reasons why parents chose to participate in care	Phenomenology	Children's hospital	16 mothers and 2 fathers	Parental motivators for involvement included: concern re relinquishing care to strangers; sense of parental duty; concern for consistency of care; parents' own hospital experiences
Kawik 1995	To determine whether parents were able to participate in care and work In partnership with nurses	Descriptive-postal survey and interviews	DGH	Survey- 65 nurses Interviews - 12 parents	Parents were willing to be involved in care but were not given enough information and nurses were reluctant to relinquish responsibility for care
Neill 1996	To describe parents' views of their experiences of participation in care	Qualitative	DGH	16 parents	Parents wanted to negotiate their involvement in care but felt isolated and left to get on with it and that information was not freely given

Callery 1995	To investigate parents' experiences	Qualitative-interviews and participant observation	Children's hospital	Parents of 24 children mostly mothers but other family members participated and 12 staff	Parents incurred financial, social and personal costs to support their child in hospital; mothers and nurses used different sources of knowledge about the child which could cause tension; parents also had needs which nurses did not assess systematically
Blower and Morgan 2000	To compare parents' and nurses' expectations of parental participation and explore whether they negotiated	40 nurses and 40 parents	Children's hospital	Structured questionnaire	Nurses and parents' expectations of participation differed and there was a lack of negotiation of roles
Shields and King 2001	International comparison of cultural differences in care for hospitalised children	In UK, 20 parents, 26 nurses + other staff + 3 other countries	Children's hospitals and other settings	Qualitative interviews and focus groups	Communication and good care were most important to parents who were also concerned re perceived lack of staff. Nurses regarded communication with parents, and meeting the child's psycho-social and physical needs as most important aspects of care

Shields and Nixon 2004	International comparison of attitudes held by parents and staff to psychosocial aspects of care	Questionnaire	Paediatric healthcare facilities in 4 countries	In UK: 249 parents and 205 staff	Staff in developed countries felt parents were under pressure to stay and participate in care
Coyne and Cowley 2007	To explore children's, parents' and nurses' views on participation in care	Grounded theory	Children's hospital and DGH	11 children, 8 mothers, 2 fathers	Nurses assumed parents would participate in care and did not feel that their relationships with parents were partnerships. Parents felt compelled to be with the child and felt responsible for the child's welfare

Being there for the child

The theme of being there for the child relates most closely to the origins of parental presence in hospital and encompasses the notions of continuing physical presence of the parent with the child and provision of emotional support for the child by the parent. Darbyshire (1994) sought to understand the experiences of parents staying in hospital with their children through individual and group interviews with resident parents and nurses. Parents in his study described choosing to stay in hospital as an automatic, almost reflex, decision based on a strong emotional response (Darbyshire, 1994). Respondents in an investigation into parents' experiences in hospital identified a powerful desire to be with their children (Callery and Luker, 1996). Similarly, all parents in Coyne's investigation into parents' reasons for participating in care saw their presence and participation as *essential* for their child's emotional and physical welfare (Coyne, 1995), and in a later study, as an unconditional aspect of being a parent and loving one's child (Coyne and Cowley, 2007).

Although based on differing research approaches, Darbyshire (1994), Callery (1997a) and Coyne (1995, 2007) used similar sampling and data collection strategies, including observation and semi or unstructured interviews with parents and nurses. Although generalisabilty is not claimed for qualitative research, the constancy of the finding that parents *need to be there* across several studies suggests this emotional response is common. Given that the majority of respondents in all these studies were mothers, it is not possible to say whether fathers experience a similar emotional need.

Parents, predominantly mothers, have also been shown to be prepared to endure personal privations in order to "be there", including poor facilities (Coyne 1995), missing meals, sleep deprivation, financial costs from travel and missed work (Callery 1997a) as well as social costs such as needing to ask for help from family and friends in relation to other children (Callery 1997a). Some parents acknowledged that even so, they themselves benefited from involvement in care

by feeling useful and regaining some control over their situation (Neill, 1996), although others experienced emotional distress (Callery, 1997a).

Nurses in studies at this time appear to share this conviction that parental "being there" is essential for the child's well-being, unlike in earlier decades. For example, all the nurse respondents to a postal questionnaire in Kawik's study (1996) agreed that parents become involved in care to provide comfort and reassurance to the child. Shields and Nixon (2004) conducted an international study comparing parental and staff attitudes to psycho-social aspects of children's care in two developed (one of which was the U.K.) and two developing countries, using an extensively trialled and tested questionnaire on parental needs, finding that in developed countries staff and parents agreed that children cope better when their parents are there.

Parents and nurses as co-workers

Researchers have consistently found that nurses regard parents as, in effect, part of the workforce and parents also see themselves as providing essential labour (Darbyshire, 1994; Neill, 1996; Callery and Luker, 1996).

Repeated studies have shown nurses to have clear expectations of the parental role (Blower and Morgan, 2000; Coyne, 2007), but this does not necessarily match parents' expectations. A constant finding is that nurses expect parents to perform ordinary child care activities, variously described by researchers as "basic care" (Casey 1995; Shields and Nixon, 2004), "continuing the parental role" (Blower and Morgan, 2000) and "basic mothering" (Darbyshire, 1994) and that this helps parents cope (Hutchfield, 1999).

One approach to understanding families' participation in care which has been taken by several researchers is to investigate factors which promote or inhibit parental involvement (Casey, 1995). Perhaps surprisingly, Casey (1995) found that social factors such as employment status, distance between home and hospital, family type or number of children were not significantly associated with variations in the level of parental involvement in care, whereas child-related factors such as how sick the child was and the length of stay in hospital were. Methodological details

are scant in this paper although it appears to have been a correlational study in relation to the care of 243 children as described by nurses and in medical and nursing notes, rather than direct observation, parent or nurse reporting (Casey, 1995), therefore the findings rest on the extent to which these records accurately reflect what happened.

Another approach is to compare parents' and nurses' views on who should do what in relation to lists of aspects of care (Blower and Morgan, 2000). There appears to be divergence between what nurses and parents expect in relation to involvement in technical aspects of care. Parents have been found to have clear views on "that's the nurse's job" (Coyne 1995; Blower and Morgan, 2000), seeing nurses as there for technological care (Coyne and Cowley, 2007). Shields and Nixon (2004) found that more staff than parents thought that parents should undertake technical aspects of care, again showing how nurses' attitudes to parents had changed.

There is evidence that parents are willing to learn technical aspects of care for the benefit of their child but experience ambivalence about this. Some parents experienced anxiety in relation to performing technical aspects of care (Evans 1994; Neill, 1996; Coyne and Cowley, 2007) or expressed reluctance to be involved in anything which caused pain or distress to the child (Neill 1996). Callery (1997a) provides a powerful example of a father whose self-identity as a father was challenged by being required to participate in a painful procedure on his child, revealing the emotional costs to parents of participation in care. However, elsewhere parents have identified that involvement in more technical aspects of care enabled them to cope better by giving them back an element of control (for example, Evans, 1994). Thus, the evidence suggests that involvement of parents in activities beyond what might be considered ordinary child care is a complex issue which would seem to require careful consideration on an individual basis.

Coyne (2007) interviewed parents, children and nurses and conducted participant observation to collect data for her investigation into parental participation from each group's perspective. She found that nurses had a clear view of how the ward should operate and how the people within it should behave with a set of unspoken

rules and norms with which parents and children were expected to comply (Coyne, 2007). Darbyshire (1994) also found that nurses expected parents to "fit in" with the ward routine. Similarly Simons *et. al.* (2001) found that nurses expected parents to ask questions and ask for help, but not too much or they would be stereotyped as complainers. Darbyshire (1994) described the process by which parents "learnt the ropes" by watching other parents or asking them, rather than the nurses, for information and advice, asserting that this was a major task of parents during the early days of living-in. From these studies, it appears there were shared norms in terms of the nurses' expectations of parents, of which the nurses seemed unaware, but the influence and power of these norms was demonstrated in the irritation at and labelling of parents who did not conform to what the nurses thought a parent should. *So what are the expectations of fathers and how would fathers know them?*

Parents are therefore in an invidious position as co-workers. They come to the ward without knowledge of the ward and its rules, anxious about a sick child, possibly worried about other children, work and other responsibilities, enduring poor facilities and possible sleep deprivation. At this challenging time, their parenting skills are under scrutiny by people they perceive as experts (Darbyshire, 1994). Yet they are expected to act as partially skilled colleagues, to be competent, concerned yet not over-anxious and willing to learn aspects of care. It is not therefore surprising that Coyne and Cowley (2007) found that parents pretended to cope in order to be seen as "good" parents, yet in doing so parents denied themselves access to the support which nurses could provide.

This raises the question as to whether parents are or are not simultaneously co-workers with the nurses *and* co-clients with their children of the nurses. Callery (1997b) found that nurses agreed that they had a responsibility to care for parents but there was no consensus as to the extent of this responsibility. There was also a sense of nurses needing to keep parental demand at bay in order to cope (Callery, 1997b). Shields *et. al.* (2004) investigated staff and parents' perceptions of parental needs using an established questionnaire; they found little agreement between staff and parents about the extent to which extent parental needs had been met.

Unsurprisingly, therefore relationships between parents and nurses is also a theme in many of the studies.

Relationships between parents and nurses

Darbyshire (1994) suggested that relationships between nurses and parents could be satisfying and rewarding when they worked well, but could also be tense and uncomfortable. Callery (1997c) suggested that a source of conflict between parents and nurses was their reliance on different sources of knowledge, the mother using her private, personal knowledge of her own child and the nurse using professional knowledge. His view is supported by Simons *et. al.*'s (2001) finding that nurses questioned parents' assessments of children's post-operative pain and often made their own judgements based on diagnostic or procedural criteria. Sharing information and expertise with children and families is central to family-centred care and health care professionals claim to recognise parents' expertise in relation to their own children (Darbyshire, 1994; Frank and Callery, 2004) yet parents feeling that they lacked information and that their opinions did not count are also persistent findings (Callery, 1996; Simons *et. al.,* 2001).

There is some evidence that nurses blame parents when relationships between parents and nurses become difficult (Darbyshire, 1994; Callery 1997b; Coyne, 2007), with labelling of parents a common phenomenon (Darbyshire, 1994), particularly in handovers (Callery, 1997b). Coyne and Cowley (2007) found that parents could come to be seen as "problem" parents by not being present when they were expected to be, not being co-operative or by being too time-consuming. This suggests that the experience of negative professional attitudes by young parents in maternity services (DCSF and DH, 2009) may also apply in paediatric settings. Young parents are known to be self-conscious when the majority of maternity service users are older than they are (DCSF and DH, 2009), and this may be even more the case when they as parents are the same age or younger than the other parents' children.

Callery (1997b) has argued that seeing fraught relationships as resulting from problem parents obviates the nurse from taking a share of the responsibility for the

relationship. Thus it serves to maintain the status quo and nurses' constructions of "good" parents and how they behave and their own self-concepts are maintained.

Unlike nurses, parents in several studies showed a reluctance to criticise nurses. For example, Simons *et. al.* (2001) examined parents and nurses working together to manage children's post-operative pain, interviewing dyads of nurse and mother, finding that most mothers gave non-committal replies to questions about the quality of their child's pain management and avoided criticising staff. This may to an extent be due to the interviews taking place whilst the child was still in hospital, although the researcher emphasised her independence from the care team and the confidentiality of data.

Parents have been found to perceive or anticipate repercussions for themselves and their children if they do not conform to nurses' expectations and there is some evidence to support these concerns. Coyne (2007) found that nurses used avoidance strategies such as spending time in areas that were out of bounds to parents. Similarly, Lee (2007) found that nurses admitted avoiding parents they perceived to be challenging by adopting the strategy of being busy. "Nurses being busy elsewhere" is a constant finding from parents (Darbyshire, 1994; Neill 1996; Coyne and Cowley, 2007). Given Lee's (2007) and Coyne's (2007) findings it would appear that whilst some of this busyness may be genuine, the practice of appearing busy in order to avoid contact with parents could be commonplace.

There is also some evidence that parent-nurse relationships change over time or with repeated admissions, sometimes but not necessarily leading to closer working together (Darbyshire, 1994; Neill, 1996). This could be explained by Coyne's analysis in relation to the norms prevailing on wards- parents learn these and conform over time so nurses see them more positively and respond more positively.

Negotiation

Many of the uncertainties between parents and nurses could be resolved through negotiation of roles and responsibilities. From their systematic review of the research on family-centred care, Shields *et. al.* (2006) identified negotiation as

central to successful relationships between parents and nurses. Negotiation has been seen as a key attribute of family-centred care (Hutchfield, 1999; Bradshaw, 2002) and central to the concept of partnership nursing (Coyne and Cowley, 2007). Children's nurses have claimed to negotiate parental involvement in care for two decades and a number of studies have explored this issue.

Blower and Morgan (2000) found discrepancies in nurses' and parental reports of negotiation, with 97.5 per cent of nurses reporting that they negotiate whilst only sixty-five per cent of parents said nurses negotiated with them. Rather than negotiating roles, Darbyshire (1994) identified nurses adopting an "inform and leave" strategy, basing this on both parental reports and his own observations of practice. As parents in several studies felt they were left to get on with it (Coyne, 1995; Neill, 1996; Blower and Morgan, 2000), this suggests that Darbyshire's finding may be happening more widely. Also, and counter to a belief in negotiation and the partnership model which suggest flexibility and adaptability on the nurse's part, sixty per cent of nurses in Kawik's (1996) study felt that nurses should not perform ordinary child care activities if parents were present. It is not clear from this study conducted by postal questionnaire whether this is because the nurses felt they should not "take over" care or whether they felt essential child care was not part of their job if a parent was present because the parent should do it. It would suggest that many nurses enter into "negotiations" with clear expectations as to the outcomes.

Experience appears to play a role in the extent to which nurses genuinely negotiate care and roles. Callery and Smith (1991) and Kawik (1996) both found that more experienced nurses showed greater flexibility in roles than junior or less experienced nurses. This appears initially to be counter-intuitive in that younger, more-recently qualified nurses will have undergone initial preparation programmes in which discussion of family-centred care, the parental role and negotiation were central, whilst these concepts would not have featured in the training of nurses who qualified many years ago. However, Corlett and Twycross (2006) concluded from their review of the international literature on negotiation between parents

and nurses that power and control are central to negotiation, parents needing to gain some control in an uncertain situation and nurses needing to keep control.

2.4.4 Discussion

International comparisons

Whilst research conducted in the U.K. has been the focus of this review, the findings discussed here bear comparison with research from other countries. Power and Franck (2008) concluded from their systematic review of the published research on parent participation in the care of their child in hospital that there were no significant differences internationally. Greater methodological diversity is evident in the non-UK based work, with a greater use of quantitative approaches, for example in relation to particular aspects of the parent experience in hospital, such as sleep deprivation (McCann, 2008) and anxiety (Tiedemann, 1997). There are also more multidisciplinary studies of staff attitudes to parental participation, for example, Daneman *et.al.* (2003), Ygge *et. al.* (2006), Tourigny *et. al.* (2008), whereas nurses alone are the focus of much of the British work.

There are similarities in findings in the British and international literature. Parents have expressed an urgent need to be with their child in hospital in U.S.A. (Dudley and Carr, 2004), Canada (Tourigny *et. al.,* 2005) and Australia (Roden, 2005). Casey's (1995) finding that social factors did not correlate with parents' level of participation is echoed in Sweden (Kristensson-Hullström, 1999). Nurses have been found to have clear expectations of parental roles in Australia (Roden, 2005), U.S.A. (Daneman et.al., 2003) and Canada (Espezel and Canam, 2003), yet parents have lacked information as to what is expected of them (Tourigny *et al.,* 2005) and in Honk Kong, regarded themselves as part of the workforce (Lam *et al.,* 2006).

The only intervention study identified was designed to test a documentary tool, the purpose of which was to facilitate nurse-parent discussion about parental involvement in day to day to day care (McCann *et. al.,* 2008). Surveys of nurses were carried out before and after introduction of the tool, with post-intervention surveys revealing that for 12 of the 24 categories attitudes had changed, with

nurses being more likely to include parents in decision-making, encourage parents to ask questions and, with parental permission, invite members of the wider family to participate in care (McCann *et. al.,* 2008). However whist the researchers claim this as evidence of the effectiveness of the tool, a programme of in-service training ran prior to the use of the tool, so this may have contributed to or been wholly responsible for the attitudinal change, rather than the tool per se.

Methodological issues

As Franck and Callery (2004) have argued, whilst many benefits are claimed for family-centred care, there is little evidence to support these claims. It is a conundrum that such a fundamental principle of children's nursing practice is not well- supported by evidence at a time when evidence based practice is a dominant discourse within nursing. That family-centred care remains ill-defined with inconsistent use of concepts such as involvement, participation and partnership is a further concern as increasing importance is being given to nursing metrics, that is measures of nursing's contributions to the patient experience (Griffiths *et. al.,* 2008).

The majority of research papers discussed here are small scale qualitative Master's or doctoral studies based on various methodologies and consisting largely of interviews with nurses and/or parents. In those studies which included observation as an element of data collection (that is, Darbyshire, 1994; Callery, 1997a, b, c; Coyne and Cowley, 2007), there is limited discussion of findings from this element of the projects. However there is consistency in findings across this body of research, and this consistency is maintained in comparisons with literature from outside the United Kingdom.

There has only been one relatively large scale study using a previously validated questionnaire (Shields and Nixon, 2004), the other quantitative studies being small-scale and using untested tools for data collection. Whilst these studies explored attitudes, there have been no recent intervention or outcome based studies on parents of children in hospital and nurses. Indeed, Shields *et. al.* (2006) found no studies met their criteria for inclusion in a proposed Cochrane review.

Table 2.1 provides a summary of the British studies included in this review. From this one can see that although the majority of researchers have used the term "parent" the overwhelming majority of participants in all of them are mothers. Only Darbyshire (1994), Callery (1997a, b, c,) and Coyne and Cowley (2007) acknowledge in their findings whether a participant was a father or mother and include limited discussion of fathers (see below). Whilst this may represent the reality of parental presence on wards when data were collected in that fewer fathers were resident, it does suggest that fathers' views and needs have been largely overlooked.

This pattern is reflected in almost all the non-UK literature on "parents", where for example the gender of participants is not discussed by Espezel and Canam (2003) or Roden (2005), or fathers were the minority of the sample, with their needs or perspectives not considered separately (Tiedemann, 1997; Lam *et al.,* 2005; McCann, 2008). The international literature which does focus on fathers in acute settings is discussed in part 2.

2.4.5 Conclusions to part 1

It has been suggested that whilst health care professionals use the term "parent", hospitals as organisations have in the past constructed parent to mean mother (Darbyshire 1994; Callery, 1995), and the same would seem from this review to hold true for many researchers in this field. This also highlights another weakness in the body of research on families in hospital - by and large the terms parent and family are uncontested and undefined, with the exception of Darbyshire and Callery. The "family" in family-centred care is taken to mean "parents" and "parents" equals mothers. If parent equals mother reflects children's nursing thinking, then this is a cause for concern, as for example, it could lead to the exclusion from care of individuals who are significant for the child, for example a social father, a grandparent or an older sibling. The view taken of families is overwhelmingly heteronormative, underpinned by the assumption of a nuclear family structure. This is surprising given the rapid social change and increased family diversity discussed in chapter 2. Furthermore the appropriateness of family centred care for minority ethnic families, among whom there may be more varied patterns of responsibility for childcare, has been questioned (Ochieng, 2003).

Priddis and Shields (2011) argue that the research literature on parents in hospital suggests that nurses have overlooked the key original purpose of parental presence identified in the Platt Report (CHSC, 1958) – the reassurance for the child of the presence of an attachment figure.

One further deficit in the current body of research on parents and nurses is the absence in any of the studies of discussion of gender; neither the sex of the nurses nor the effects of parent/nurse gender on behaviour and relationships are considered. Whilst children's nursing is a predominantly female profession, it is not exclusively so. The absence of a discussion of gender means that a significant structural factor in society at large, the social environment of the ward and relationships between mothers, fathers and nurses has been overlooked in children's nursing research.

The British literature on parents' involvement in their children's acute care in hospital reveals little of fathers' experiences, and in general fathers' and mothers' experiences have not been compared, although there are some suggestions in Darbyshire (1994) and Callery (1995) that fathers experience their child's hospitalisation differently from mothers. Darbyshire (1994) found fathers and family members other than mothers were on the periphery of care. There are similar suggestions in the international literature, for example, Kristensson-Hallström (1999) and Scrimin *et. al.*(2009).

In part 2, the British and international literature which has focused on fathers is considered. Given the differences in health care provision and possibly socio-cultural expectations of men as fathers, the direct applicability of findings from overseas to the British context may be limited.

2.5 PART 2 FATHERS, CHILDREN AND HEALTHCARE

2.5.1 Overview

There are three broad areas of research on fathers' experiences in relation to their children's health: experience in relation to their children's routine healthcare (such as developmental reviews, immunisations and minor illnesses; the experiences of

children's acute health care and fathers' experiences in relation to childhood chronic illness. The greatest number of studies by far was found in relation to the last of these, supporting Isacco and Garfield's (2010) claim that healthcare research with fathers has focused on severe and atypical situations.

2.5.2 Fathers and their child's routine healthcare

There is a little research exploring fathers' involvement in their children's routine health care with the exception of new fathers which is not considered here. An American study by Garfield and Isacco (2006) explored the involvement in health care of fathers in families designated as "fragile". The sample in this study was ethnically diverse (56% Black, 28% Hispanic and 15% white), unlike the participants in the studies discussed below, and the majority were not married to the child's mother. Also, although class is not discussed explicitly, educational attainment may be indicative of this, and in the sample, only 2 of the 32 fathers had college degrees or higher (Garfied and Isacco, 2006).

The study revealed that 53% of fathers had attended a "well child visit" and 83% had seen a doctor with their child in the previous year (Garfied and Isacco, 2006). Whilst this study does not clarify how families become designated by professionals as" fragile", it does suggest that father involvement in child health is not restricted to white, middle class, married families. Similarly, in Moore and Kotelchuck's (2004) investigation into motivators and barriers to fathers' involvement in children's health, in which 86% of participants were black, 89 per cent had attended a well-child visit. These findings are supported by Hallberg *et. al.*'s study (2007) of a randomly selected sample of Swedish fathers' perceptions of and involvement with their children's health, in which they found few statistical differences between fathers in relation to the variables of class, father's age and number of children. This contrasts with Moore and Kotelchuck (2004), who found fathers who were non-black, or had higher qualifications or younger children were more likely to attend. Societal structure varies trans-nationally as do the meaning and effects of issues such as race and class so whether one would find similar

patterns within the U.K. is open to question, but there is a little international evidence that father involvement in health care is not restricted to the white middle class, but evident across social strata.

The majority of fathers in Garfield and Isacco's study (2006) were satisfied with their encounters with health care professionals although eighty per cent identified barriers to their involvement which were either related to their work patterns (such as clinic appointment times in working hours) or to their relationships with their child's mother. In Moore and Kotelchuck's (2004) study, 46% of participants also reported work-related barriers. Negative experiences were reported by some, related to being perceived as having a lesser emotional bond with the child, feeling they were viewed with suspicion by staff and perceiving they received a lesser standard of service than mothers (Garfield and Isacco, 2006).

2.5.3 Fathers of children with chronic illness

My study is concerned with children experiencing unplanned admissions, some of whom may have or go on to have a chronic illness and given the paucity of information on fathers in acute settings, this body of research may provide some understanding of how fathers cope with childhood illness and healthcare, so is included in this review. Pelchat *et. al.* (2003) have argued that fathers of children with disability have been evaluated in terms of the support they provide for mothers. Yet there is a need to for fathers to be seen in their own right. Therefore whilst there is quantitative research which compares mothers and fathers on variables such as stress and quality of life, it has not been included in this review as the focus is on fathers' experiences *per se.* The research discussed in this section provides evidence of fathers as active participants in complex aspects of care and disease management.

The literature relating to fathers of children with chronic illness is extensive and derives from diverse professional perspectives including nursing, psychology, medical sociology and social work. The greater part of the research consists of small-scale qualitative studies exploring fathers' experiences of having a child with

a specific condition such as diabetes (Sullivan-Bolyai *et. al.,* 2006) cystic fibrosis (Hayes and Savage, 2008), juvenile idiopathic arthritis (McNeill 2004; Waite-Jones and Madill, 2008), asthma (Cashin *et. al., 2*008) HIV/AIDS (Wiener *et. al.,* 2001), and cancer (McGrath and Chesler, 2004; Clarke, 2005; Bonner *et al.,* 2007) or relating to chronic illness in general (Katz and Krulik, 1999, Goble, 2004; Peck and Lillibridge, 2005; Ware and Raval, 2007; Hobson and Noyes, 2011).

Themes that occur across these papers are the social and emotional impacts of having a child with chronic illness, coping strategies and role expectations.

Social effects

The social effects on fathers of having a child with a chronic illness include social isolation, with family, friends and others seen as not understanding (Katz and Krulik, 1999; Goble, 2004; McNeill, 2004; Waite-Jones and Madill, 2008; Hobson and Noyes, 2011), or not being as supportive as anticipated (Ware and Raval, 2007). In some studies, fathers reported increased strain on the couple relationship, but also increased closeness with their partner along with increased closeness to the ill child (McNeill, 2004; Ware and Raval, 2007) or to the other well children in the family (Goble, 2004). Some fathers felt that having a chronically ill child had led to increased division of labour within the family along gendered lines (Goble, 2004; Waite-Jones and Madill, 2008) with consequent greater pressure on fathers to provide financially. Yet this is not a universal finding. Employed fathers in Hobson and Noyes' study stressed the importance of earning and providing to them, and this did not preclude them from undertaking complex aspects of care for their child, whilst others did not work and were their child's primary carer (Hobson and Noyes, 2011).

Some participants saw health services as being oriented towards women (Clarke, 2005; Ware and Raval, 2007) and reported that they as men felt they had been treated differently from women to the extent of feeling ignored or abandoned by health care professionals (Hayes and Savage, 2008; Ware and Raval, 2007). Dealing with health care professionals was seen as challenging by some participants in Chesler and Parry's (2001), Clarke's (2005) and Waite -Jones and Madill's (2008)

studies. Clarke (2005) discusses the structural barriers to fathers' greater involvement in medical care, such as appointment times within normal working hours. This can mean that fathers have to depend on second hand medical information from the child's mother, adding to stress and anxiety and potentially causing conflict between the parents (Chesler and Parry, 2001). Chesler and Parry (2001) contend that children's oncology care is highly gendered; mothers tend to stay with children, consequently the largely female staff become more accustomed to supporting women and may misinterpret male assertiveness as aggression, resulting in men being marginalised further.

Emotional effects

In terms of the emotional effects of childhood chronic illness on fathers, the most prominent theme is a sense in the literature of loss and chronic sadness. Participants in Waite-Jones and Madill's study (2008) of fathers with children with arthritis described multiple losses- of a 'normal' family life, of an ideal healthy child, in particular of their role as a protector and provider and of opportunities for shared family and father/child activities. Fathers of children with diabetes reported chronic sadness (Sullivan-Bolyai *et. al.,* 2006) as did participants in Ware and Raval's (2007) study of fathers of children with life-limiting illness. Fathers also faced anxiety arising from uncertainty in relation their child's condition from day to day (Cashin *et. al.,* 2008, Hayes and Savage, 2008) and fears for the future - either in relation to the effects or management of the illness or their child's position in society as an adult (McNeill, 2004, Sullivan-Bolyai *et. al.,* 2006; Swallow *et. al.* 2011).

Katz and Krulik (1999) found that fathers of chronically ill children reported lower self-esteem than a control group of fathers with healthy children, postulating that loss of self-esteem can be exacerbated when the mother becomes "expert" in the child's care as this diminishes the father's sense of competence. Waite -Jones and Madill (2008) however suggest an alternative explanation –that fathers of chronically ill children judge themselves critically against the traditional father role of protector, which diminishes their self-esteem. Again this highlights the significance of the protector role to fathers.

An almost universal finding in the literature on fathers of children with chronic illness is an expressed reluctance among the participants to discuss or show their feelings with family members or professionals. This reluctance is identified by the men as arising from: a need to "be strong" and support their partners (Chesler and Parry, 2001; McNeill, 2004, Sullivan-Bolyai *et. al.,* 2006; Ware and Raval, 2007), a reluctance to burden partners with their feelings (McNeill, 2004), a view that men do not talk about or show their feelings (Ware and Raval, 2007; Waite- Jones and Madill, 2008; Hayes and Savage, 2008) or the attitude that it is better not to talk about issues in order to avoid painful emotions (Hayes and Savage, 2008).

Coping strategies

Fathers in several studies identified a range of coping strategies, including denial (Waite-Jones and Madill, 2008), distraction (McNeill, 2004; Peck and Lillibridge, 2005; Waite-Jones and Madill, 2008), "time out" (McGrath and Chesler, 2004), focusing on the here and now (Peck and Lillibridge, 2005; Hayes and Savage, 2008), taking positive action (McNeill, 2004; Sullivan-Bolyai *et. al., 2*006; Ware and Raval, 2008) and maintaining a positive outlook (McNeill, 2004).

Whilst some fathers saw long working hours as an economic necessity, for others work provided an essential distraction and gave a sense of normalcy. Some of Chesler and Parry's participants (2001) reported feelings of guilt and alienation from the family as a consequence of continuing to work during their child's illness. The use of work as a refuge by fathers of children with cancer is discussed by Chesler and Parry (2001) and Bennet Murphy *et. al.* (2008).

"Time out" as a notion encompassed the emotional withdrawal cited by Hayes and Savage's participants (2008), being alone with their thoughts (McGrath and Chesler, 2004), socialising outside the family (Waite-Jones and Madill 2008) and sport (Peck and Lillibridge, 2005). Being actively involved in the child's care, taking an active role, planning, showing initiative were strategies which helped fathers cope with their sense of powerlessness and uncertainty. Yet by working long hours or absenting themselves from the family in other ways, fathers might limit their

opportunities for active involvement, thereby increasing their sense of powerlessness, leading to further avoidance through longer absences.

Interestingly there are contrasting attitudes towards information- seeking in different studies. Fathers of children with asthma saw learning to manage the disease and understand it as helpful (Cashin *et. al.,* 2008) and seeking information enabled fathers in Ware and Raval's (2007) study to take control, whereas fathers of children with cystic fibrosis in Hayes and Savage's study (2008) and Peck and Lillibridge's study (2005) (in which the children had diverse conditions) described avoiding finding out more because such knowledge could increase stress and cause powerful emotions. Similarly, Baumann and Braddick (1999) found that some fathers of children with congenital anomalies actively sought information whilst others were reluctant to learn about their child's condition. Swallow *et. al.* (2011) also found that fathers sought information pro-actively, gaining a sense of control from so doing.

Role expectations

A further theme evident in the literature concerning fathers of children with chronic illness relates to how fathers' experiences challenged their gendered role expectations. Across the world, three social roles define masculinity in the context of fatherhood – to procreate, provide and protect (McNeill, 2007).

The literature on fathers of children with chronic illness provides evidence of fathers directly giving care, reflecting today's changing fatherhoods. Examples include commitment to a range of direct care giving, including routine child care for the affected child, becoming the main carer for siblings when a mother's time was consumed by the needs of an ill child, becoming the main carer for the ill child (Clarke, 2005; Bonner *et. al.,* 2007), performing medical aspects of care (Clarke, 2005; Sullivan-Bolyai *et. al.,* 2006) and providing emotional support for all family members (Chesler and Parry, 2001). Yet some fathers face challenges in this direct care giving. Mothers of children with Down syndrome recognised that they did not leave much room for fathers to participate and doubted fathers' capability to provide adequate care (Pelchat *et. al.,* 2003), providing evidence in support of the

notion of maternal gatekeeping. Therefore it would seem appropriate in the light of these findings and in the era of involved fatherhood, to add participation in care to the roles of the father.

Whilst the provider role has already been touched on in this discussion, this appears to have greater significance in some studies than others and may depend in part on whether the child's health care is publicly funded- as in Israel (Katz and Krulik, 1999), Canada (Clarke, 2005) and the U.K. (Ware and Raval, 2008) or not, as in the U.S.A. (Goble, 2004, Wiener *et al.,* 2001). Overall there is limited discussion to date of this aspect of fatherhood in relation to children's healthcare.

In terms of the protector role, fathers in McNeill (2004), McGrath and Chesler (2004) and Clarke (2005) identified that their child's chronic illness challenged this aspect of their identity in relation to the ill child and other family members. The need to be strong for others was discussed earlier. One father in McGrath and Chesler's study (2004) spoke of how his role as a father was "to fix things", and of the anger and frustration resulting from not being able to "fix" his son's cancer. This may in part explain why getting involved and taking action (discussed above) were effective coping strategies for many men. Interestingly, this study is the only one of those discussed here which directly acknowledged anger as a response to chronic childhood illness. Swallow *et. al.* (2011) noted that:

"it was consistently fathers who took responsibility for protecting their child during upsetting events" p 5

The protector role is also expressed in discussion of the need for advocacy for their ill child in health care situations (McNeill, 2004; Clarke, 2005). In both these studies fathers recognised that advocacy work (such as asking awkward questions or monitoring the performance of hospital staff), could bring them into conflict with health care professionals but felt it was necessary for their child's well-being. They therefore knowingly risked unpopularity in performing a protective function. Given the norms of parental behavioural expected by nurses (discussed in section 2.4.3) one can see that there is potential for tension to arise between fathers and nurses from when fathers behave in this way.

Some positive elements emerge from the literature on fathers with chronically ill children. A sense of gradual adjustment, acceptance over time and of personal growth is evident in some studies (e.g. Chesler and Parry, 2001; McNeil, 2004). Despite intra-family stresses and strain, mothers and fathers reported stronger marriages and closer families (Baumann and Braddick, 1999; Chesler and Parry, 2001). Fathers described opportunities to become more involved in family life that they would not have had if their child were healthy (Hayes and Savage, 2008) and heightened relationships with either their partner, the ill child (McNeill, 2004; Ware and Raval, 2008) or their healthy children (Goble, 2004).

A further point of note is the notion of complementarity and partnership in the couple relationship discussed by Chesler and Parry (2001) in relation to roles and also by McNeill (2004) and Swallow *et. al.* (2011). In a British study, So for example a father's focus on the instrumental - getting on with it- whilst the mother focuses on the emotional aspects of care, works to the benefit of the family as a whole. Therefore whilst there is a need to understand fathers' (and mothers') reactions and perspectives to chronic illness, neither should be considered in isolation.

2.5.4 Fathers in acute settings

There is limited literature on fathers' experiences in acute settings and it has not been possible to undertake a thematic analysis. It has not been possible to identify any studies which sought specifically to understand fathers' experiences of their child's acute hospitalisation. In the British studies of parents' experiences: Darbyshire (1994) suggests that fathers were marginalised by organisational policies which constructed "parents" to mean mothers (for example the facility for resident parents was called the "mothers unit") and there is a suggestion that fathers were largely ignored by nurses; Callery (1995) found that fathers were involved in care but that their role was as substitute mothers or an optional extra; Coyne (2003) found fathers acting as supporters to mothers –by relieving her at the child's bedside and sharing duties at home. In echoes of McNeill (2004), Coyne (2007) also speaks of the mutuality of couples relating and responding to each other's situation.

There is some international literature which examines specific aspects of fathers' involvement during their child's admission to a children's ward, and there is more which relates to paediatric intensive care or neonatal intensive care which has not been included here. In Kristensson-Hallstrom's study (1999) into factors influencing levels of parental participation in care, Swedish fathers said they wanted to participate in only those aspects of care with which they were already familiar more commonly than mothers whereas mothers wanted to participate as much as possible in care provided they had guidance. This may suggest a lack of confidence in fathers or a reluctance to expose their competence to nurses' scrutiny.

Board (2004) explored sources of stress for fathers of children in PICU and on a general ward, finding that 70% of participants from the general ward reported symptoms of stress including headaches, having unpleasant thoughts, being easily annoyed and worrying too much (Board, 2004). Given nurses' expectations of parental behaviour discussed in part 1 and fathers' reluctance to talk about feelings outlined above, one might speculate how, or indeed whether, stressed fathers are perceived and supported by staff. Participants were also asked to identify the sources of their stress, with 90% of general ward fathers citing "seeing their child have needles" and 80% "not knowing how to help" (Board, 2004). Stress in relation to both these aspects of their experience could be seen as arising from challenges to the protector role.

Two studies relate to children undergoing surgery. Tourigny *et. al.* (2004) videorecorded and classified mothers' and fathers' presence and actions in the first hour after their child's surgery, rather than relying on self-reported behaviours. They found that although mothers were present for longer at the child's bedside in the first hour post-operatively, mothers and fathers demonstrated a similar range of helpful behaviours, though fathers showed them with less frequency (Tourigny *et. al.,* 2004). In this study therefore there was evidence that mothers and fathers adopted similar roles in relation to their child in hospital so the study supports the notion of fathers as participants in care. Thompson *et. al.* (2009) found higher agreement between fathers' pre-operative predictions of their child's level of anxiety at anaesthetic induction and scores from a behaviour ratings scale

completed by researchers than mothers' predictions. At face value this would suggest that fathers were better able to predict their child's anxiety than mothers. Rather than suggest that their findings are evidence that fathers may be reliable informants about their child's behaviour however, the researchers argue that mothers' predictions may have been based more on their child's internal state than behavioural and that the children's anxiety cues were too subtle to be picked up by the assessment tool used, resulting in falsely low anxiety scores, so that in fact mothers' predictions were accurate (Thompson *et. al.,* 2009).

2. 6 METHODOLOGICAL ISSUES ARISING FROM THE LITERATURE ON FATHERS' EXPERIENCES

A note of caution is needed in terms of research bias. It could be that those fathers who experience the challenges of childhood chronic illness in the ways identified here are more likely to participate in research than fathers who do not. A further source of bias is that in the overwhelming majority of the studies discussed, participants were predominantly white and middle class, acknowledged by the authors as limitations of their studies. So despite a burgeoning literature on fathers of children with chronic illness, the extent to which a comprehensive understanding has yet been achieved is open to question.

Much of the research discussed in part 2 has been dependent on self report. One might question the validity of this given some fathers' need to be seen as "strong". Whether there would be discrepancies between fathers and mothers in reports of the extent of fathers' involvement or care giving in relation to chronic illness, as there are in relation to these factors in general studies of parenting is open to question also.

The approach researchers take as to who is considered a father is variable. Frequently this is not discussed at all, suggesting the researchers see this as unproblematic, despite the diversity of family form and structure. Garfield and Isacco's (2006) participants were all biological fathers, but not necessarily in a relationship with the mother at the time of the study whereas participants in the

Swedish study were all living with their biological or adopted children (Hallberg *et. al.,* 2007). Participants in Moore and Kotelchuck's (2004) study self- designated as fathers. In diverse societies it would seem essential that researchers establish and specify their determination of "father" in future. Ahmann (2006) urges health care professionals to be open-minded and inclusive in their approach in relation to the father role in families, arguing that:

"The person or persons who see themselves in the paternal role, whether or not they are biologically related to the child, are the persons most likely to be involved participants in the child's care" (p 88).

2.7 CONCLUSIONS

In relation to the first question for this literature review, the origins of family centred care, at least in relation to hospitalised children in the U.K., have been shown to lie in the early development of psychological understandings of relationships between mothers and children. The influence of these origins is evident in the way that hospitals as organisations have constructed resident parent to mean mother. The expectations of the parental role in hospital have evolved from a passive presence to active involvement in care. Yet there are inconsistencies in the literature in the use of terms such as involvement, participation and partnership. It appears that family centred care is a practice ideal rather than reality and nurses in acute settings rarely look beyond the adult and child in front of them to the broader family context.

Much of the research on parenting and even fathering uses criteria derived from studies of mothering, such as nurturing behaviours, to assess fathering performance and while this has been challenged in general research on parenting, that challenge is not evident in the nursing literature. Children's nurses in general have not distinguished between fathering and mothering in their discussions of working with parents nor considered their experiences separately. They appear to have based practice with parents of children in hospital on research that has been conducted with mothers.

There is no recognition in the research that some families may be considered "vulnerable" and the concept of "vulnerable fathers" (discussed in chapter 1) does

not appear in the children's nursing literature. Nurses do not appear to have considered that some parents, such as the very young or marginalised, may be intimidated by the hospital environment or their perceived status of healthcare professionals; they may therefore need additional support to participate in their child's care.

Fathers are portrayed in terms of being a substitute or support for mothers. There is little evidence that nurses seek to acknowledge, understand and support the father's direct relationship with the child, not just that which is mediated through the mother, whilst also respecting and supporting the functioning of the family as a unit.

As to what is known about fathers' experiences of their children's health care, illness and hospitalisation, the experiences of fathers as parents of acutely ill children in hospital remain largely unexplored. There are suggestions that fathers are marginalised during children's hospitalisation, though there is evidence from the literature on fathers with chronic illness that fathers are often actively involved in their child's care.

The contrast between the absence of fathers from research on in-patient settings and the quantity of literature on fathers of children with chronic illness is striking. Much of the chronic illness research has been undertaken by researchers from non-nursing backgrounds, such as psychology. This may reflect greater multi-disciplinary involvement with families when there is a child with chronic illness compared to an acute hospital admission and greater readiness to undertake research among these professionals. It may also reflect greater family-centredness among professionals involved with the child in the home – it is easier for them to see and understand the broader family context than in the acute setting. Families in the community may face fewer structural barriers to paternal involvement in care than they do in hospital settings.

Discussion of gender is absent from the literature on family centred care and the experiences of parents and nurses. It would seem from the literature that nurses in the acute setting appear to see "parent of a child in hospital" as an ungendered

role, while simultaneously and unknowingly holding highly gendered expectations of parental role and behaviour which arise from research and experience with mothers.

This literature review therefore demonstrates the need for an understanding of fathers' perspectives on their experiences during their child's hospitalisation for acute illness, whether resident in hospital or not.

3.1 INTRODUCTION

The purpose of research is to provide information that is both true and relevant to some legitimate public concern (Hammersley, 1992); therefore research should be judged by its credibility and relevance. In this chapter, I establish the credibility of the study by specifying the underpinning methodological thought and consequent research design. The relevance of the study is that it will contribute to the evidence for children's nursing practice in relation to family centred care by increasing understanding of fathers' experiences of involvement in care when their child is in hospital.

There is a need for congruence between the aims of research and the design/methods used to complete the project. In this chapter the selection of a critical realist approach, a qualitative research strategy and an ethnographic method are justified in relation to the aim and questions of the project. The methods of data collection and analysis are stated and the reasons for their selection given. The process of gaining access to the setting and ethical approval for the study is explained. Strategies used to enhance the rigour and credibility of the research are discussed.

3.1.1 Aim of the study

The aim of this study is to gain understanding of fathers' experiences of involvement in care when their child is admitted to hospital on an unplanned basis, through answering the following questions:

What do fathers do during their child's stay in hospital and what determines this?

What determines their level of involvement in care and decision-making, how and why?

How do nurses and fathers relate to and understand one another?

How are partnerships between fathers and nurses constructed and expressed?

It can therefore be seen that I am concerned with the actions of individuals and the social structures within which those actions occur, the interactions between structures and actions and the meanings they have for individuals.

3.2 OF KNOWLEDGE AND BEING

It has been argued that positivist and constructivist approaches to research leave out factors which are invisible to existence or unmeasurable or that are not expressed by the researched (Bergin *et. al.,* 2008). So for example, the need for research into aspects of nursing practice to entail more than discussion with nurses or patients is demonstrated by Simons *et. al.'s* investigation (2001) in which dyads of parents and nurses were interviewed forty-eight hours after a child's surgery to determine the degree of parental involvement in pain management. There was little agreement between the parents' and nurses' accounts and some significant discrepancies. Whilst the study reveals nurses' and parents' perceptions of involvement, without observation of interactions and interventions there is no opportunity to assess the context of participants' perceptions and the complexity of nursing care is not revealed. Brink and Edgecombe (2003) argue that observation and questioning of practice during practice is the most valid way of researching practice. Ethnography is a method which can reveal the complexity and ambiguity inherent in social interaction (Agar, 1980), the element that is missing in Simons *et. al.*'s study.

The word "father" expresses a concept which encompasses both a role and a relationship. I argued in chapter 2 that the concept "father" is both real in a positivist sense and socially constructed. It is real in the sense that a biological, demonstrable relationship between a child and the adult male whose genes she or he shares exists outside of both of their perceptions, even if they have never met. It is socially constructed in that each of their perceptions of the relationship is shaped by the expectations, norms and values attributed to that relationship by society. These expectations have changed over time, being modified by each generation,

yet also constrained by broader societal structures. An individual father may be unaware consciously of how these influences shape his actions and decisions at any point in time. This argument reflects a critical realist standpoint and the study was constructed to be consistent with that view.

3.2.1 Critical realism

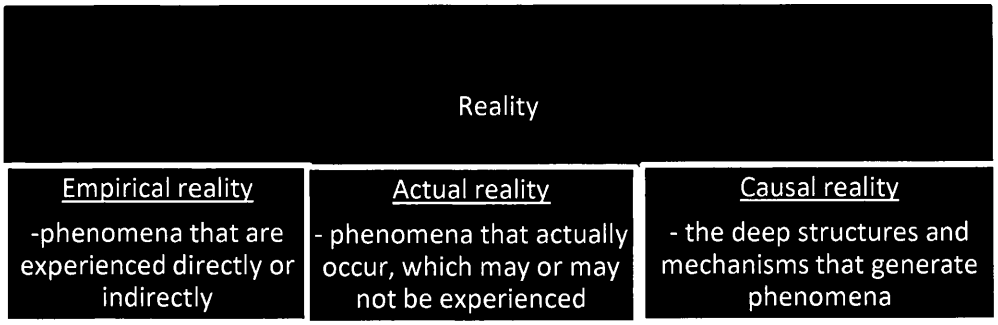
Critical realism is a philosophical position developed by Bhaskar (Bhaskar, 1989). Critical realists hold that there is an observable world of events which is independent of human consciousness, but knowledge of this world is socially constructed (Denzin and Lincoln, 2008). Critical realists hold the view that there is an objective reality -which Bhaskar (1997, cited by Lipscomb, 2008) terms intransitive- but human beings have access to that only through their own perceptions – transitive knowledge, their understanding of that reality, which is contingent on their socio-historical context (Lipscomb, 2008). Thus our understanding of the natural world, as expressed in scientific theories, frameworks, models and so on, is transitive- it can and does change, but that does not mean that the natural world changes, that is -it is intransitive.

Within critical realism, three levels of reality are proposed: empirical reality (that is, experienced events), actual reality (that is all events, whether experienced or not) and causal reality – the structural mechanisms which generate events (Bhaskar 1989), see figure 3.1. One may not be consciously aware of a causal reality, but its existence is confirmed by the events it causes. Causal reality explains events.

Bhaskar (1998) uses the example of the movement of iron filings in response to a magnet to explain. Whilst such movement can be seen, it can only be explained if one accepts and understands the concept of magnetism, which itself cannot be seen, experienced or measured directly but the evidence of its effects are proof of its reality (Bhaskar, 1998). Magnetic force is thus more than a theoretical concept- it is a generative mechanism- causing the iron filings to move.

Figure 3.1

The three ontological domains of reality (Bhaskar 1989)



Critical realism applies to the social world as well as the natural sciences. In contrast to the natural world however, the social world is mutable. Society is just as real as magnetic force, in that it exists and its effects can be seen outside of human thoughts (Bhaskar, 1998). Unlike moving iron filings, all human actions occur within a context which pre-exists and gives meaning to those actions and which those human actions either maintain or transform (Porter and Ryan, 1996). Social phenomena- the interpretations and meanings individuals give to events, may be socially constructed but they are nonetheless real. Layder (2006) has argued that social constructionism reduces the significance of individuals' personal characteristics and unique responses. Furthermore, aspects of social structure lie beyond individual consciousness yet still influence actions beyond awareness (Alvesson and Sköldberg, 2009). Hence a social constructionist approach is insufficient for a full understanding of the social world.

Even so, the relationship between structure (i.e. broader society) and action (the individual's decisions and behaviour) is two-way. As Porter (1998) argues:

"An adequate explanation of human actions needs to include identification of the structures that influence those patterns" p 173

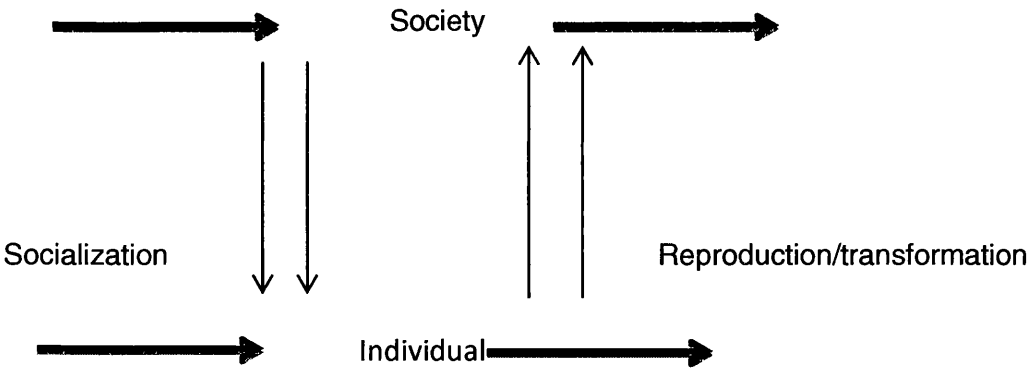
Societies only exist as the outcomes of human agency, whilst at the same time society is the context for human agency, without which actions do not make sense (Bhaskar 1998). Collier expresses this succinctly: *"people make societies and societies make people"* (Collier 1994 p 140).

This two-way relationship between society and individuals means that society is not fixed, but is subject to change, as Houston (2010) asserts

"the person can actively transform the social world and is in turn transformed by it" p21

Bhaskar's Transformational Model of Social Activity (Bhaskar 1998) represents this interaction between people as individuals and society at large, showing how society changes in response to individual agency whilst individuals' agency shapes society in an ongoing process (see figure 3.2).

Figure 3.2 The transformational model of the society/person connection (Bhaskar 1989)



One can see from this model how fatherhood can change over time. Individual fathers develop an understanding of fatherhood in society which influences their own actions, beliefs and motivations as fathers where they can choose to reproduce or transform fatherhood for themselves. These in turn can contribute towards shaping fatherhood in broader society, meaning that subsequent generations are influenced by different societal meanings and expectations of fatherhood.

However, knowledge of society does not reduce to the knowledge of people as individuals, rather society is relational, made up of the relationships between individuals and groups and the structures which govern them (Collier, 1994). The

difference between the movement of iron filings and human agency is intention and the meaning which the agent gives to the context. To understand society, there is a need to understand both human actions and the societal structures within which those actions take place (Porter, 1996). To a critical realist, both human actions and social structure are real, neither is produced nor determined by the other; they are inter-related and cannot be separated (Aull Davies, 2008).

Critical realism is a standpoint which is critical towards knowledge which is always fallible. All knowledge is seen as socially produced but this does not mean that all knowledge is equally valuable (Danermark *et. al.,* 1997). Critical realist social science see the social world as not just socially defined (as for example in social constructionism), but also socially produced, and is therefore concerned with the interaction between social structure and human agency and with the causal mechanisms that operate within the social world (Danermark *et. al.,* 1997).

3.2.2 Critical realism in relation to my study

The goal of critical realist social research is

"not to identify generalizable laws (positivism) or to identify the lived experience or beliefs of social actors (interpretivism); it is to develop deeper levels of explanation and understanding" (McEvoy and Richards, 2006)

This is compatible with my goal since I sought to identify not just a description of fathers' experiences but also an understanding of how and why their experiences were as they were. According to Bhaskar (1998), the social scientist seeks to identify and explain patterns of social behaviour, not just for knowledge in and of itself, but, to provide knowledge that can be used to improve the structural organisation of society through exposure of the social structures influencing actions. Thus it is not a value free philosophy, there is an emancipatory element, and this is a further element of "criticality" in critical realism.

As a children's nurse and nurse teacher, the goal of my study is to identify knowledge which has the potential to inform and potentially improve children's nurses' practice with fathers. There is therefore compatibility between my goal and my philosophical approach.

Within critical realism, the social world is seen as comprising of numerous interconnecting systems (Houston, 2001). Therefore in relation to my study, in order to understand fathers' experiences in hospital, one must have a general understanding of the positions of men, parents, and particularly fathers, and nurses in society in general, in the family and within the social milieu of the children's wards. Also one must understand the *particular* circumstances of the individual. A father's experiences when his child is in hospital cannot be fully understood without an appreciation of his usual circumstances- such as his role in the family, his work situation, his relationship with both the child and the child's mother, and his own wishes, values and psyche.

3.3 RESEARCH APPROACH

Critical realism is a philosophical tradition which supports a wide range of approaches to research (Sayer, 2000). Rather than prescribe a particular research approach, critical realism requires the researcher to select methods based on what they want to know and what different methods can help them learn (Danermark *et. al.,* 1997; McEvoy and Richards, 2006). The open nature of qualitative research is seen as a key strength from a critical realist point of view because it can allow the researcher to respond to what emerges during the course of an enquiry (McEvoy and Richards, 2006).

3.3.1 Qualitative research

In qualitative research, the researcher is concerned with the meanings of the topic of interest for the participants in the study (Savage, 2006), so precedence is given to their perspectives (Avis, 2005), rather than setting out to test a hypothesis or discover the scale of the phenomenon. A qualitative research approach is indicated when a problem or issue needs to be explored or silenced voices heard (Creswell, 2007). In chapter 2 the predominant absence of fathers from studies examining the experiences of "parents" in hospital with their child was established. Although there is some evidence relating to fathers' experiences when their child has a long term condition or is critically ill, fathers' experiences during acute, unplanned admissions have not been investigated, so I would argue theirs are silenced voices

needing to be heard. Similarly nurses have not had the opportunity to discuss the challenges they face when working with fathers, be they societal, institutional or personal.

Creswell (2007) identifies nine characteristics of qualitative research: i) a natural setting, ii) the researcher as key instrument, iii) use of multiple sources of data, iv) inductive data analysis, v) emphasis on participants' meanings, vi) an emergent design, vii) the use of a theoretical lens, viii) interpretive inquiry and ix) the goal of providing an holistic account. These characteristics can be found in different research designs such as grounded theory, phenomenology, case study and ethnography, each of which has its own methods, design and epistemological standpoint.

Whilst qualitative research is therefore flexible and may evolve over the course of a study, this does not mean that the researcher can take an unplanned approach. Creswell (2007) argues that the rigour of qualitative research is enhanced when the researcher uses one of these recognised approaches, rather than an ad-hoc use of qualitative methods. Similarly Holloway and Todres (2005) maintain that the researcher should demonstrate consistent use of methods coherent with the foundations of their chosen approach in order for their research study to make up a coherent whole.

3.3.2 Rationale for choice of approach

It is not possible to separate what people say from the context in which they say it (Creswell, 2007) so a research design that can that is sensitive to contextual data is necessary. Whilst context is an element of grounded theory and case study research, the context in phenomenology is the lived experience itself. The view that lived experience is reality diminishes the significance of larger social structures which influence that lived experience (Porter and Ryan, 1996), so in the context of my study would ignore the social factors that I have shown in chapter 1 to influence fatherhood and of which individual fathers may not be consciously aware. Therefore a phenomenological approach would not have addressed the research questions. The aim of this study was not to produce theory but to develop an

understanding of fathers' experiences so a grounded theory approach would have been inappropriate. Ethnography is the research approach best suited to description, interpretation and understanding of complex social settings (Holloway and Todres, 2005) and was therefore the approach adopted in this study.

3.3.3 Ethnography

The origins of ethnography lie in social anthropology and the colonial endeavours of Boas, Malinowski and Mead to understand the cultures of non-Western societies in the early twentieth century (Savage, 2006; Creswell, 2007). These early studies involved prolonged engagement in a different society and resulted in what were seen as factual accounts of these societies. The approach was taken up by sociologists in Chicago in the 1930s and used in the study of various deviant groups (Brewer, 2000), with an agenda to bring about social reform. Thus it became associated with understanding the different- the other, the strange, the foreign.

Since its early days ethnography as a research approach has developed and fractured into many different types. However Savage (2006) sees the differences between these types being of degree and emphasis in relation to truth claims and method rather than kind. Brewer (2000) also argues that the differences between these types of ethnography are in the researchers' claims as to the status of their accounts and by what criteria they should be judged. Similarly O'Byrne (2007) argues that regardless of the type of ethnography claimed, the basic elements remain the same. Wolcott (1999) argues that the purpose of ethnographic research:

"is to describe what the people in some particular place or status ordinarily do and the meanings they ascribe to what they do"

Contemporary ethnography remains concerned with culture but in a more focused way, often in relation to specific problems (LeCompte *et. al.*, 1999). Spradley (1980) defines culture as "the acquired knowledge that people use to interpret their experience and generate behaviour". He argues culture consists of an explicit element- rules, norms, beliefs that people in a particular setting can identify and verbalise- and a tacit element- observable behaviour arising from rules, norms and

beliefs that people are unable to express yet follow (Spradley, 1980). Ethnographic research enables the researcher to observe those behaviours and question their meaning through interview, either during or after the event (Brink and Edgecombe, 2003).

3.3.4 Definition of ethnography

Ethnography's varied history means that there is not one standard meaning (Hammersley, 2009). However, to provide a coherent approach, this study is founded on Brewer's definition (2000):

"Ethnography is the study of people in naturally occurring settings or "fields" by means of methods which capture their social meanings and ordinary activities, involving the researcher participating directly in the setting, if not also in the activities, in order to collect data in a systematic manner but without meaning being imposed on them externally" p6.

Brewer argues that ethnography is both method and methodology, that is, it is a set of procedural rules for collecting data which derive from theoretical and philosophical foundations. Its goal is to understand culture, the social meanings and actions of people in particular settings and the way in which these meanings influence actions (Brewer, 2000).

3.3.5 Characteristics of ethnography

Hammersley (1992) identifies the following features of ethnographic research:

- behaviour is studied in every day contexts

-data are collected by a range of methods, principally observation

-data collection is flexible and unstructured to avoid the imposition of external factors

-the focus is normally on a single setting or small group

-analysis involves giving meaning to the observed actions.

Ethnography produces "thick description". Ryle (1968) used the term thick description to encapsulate the multi-layered description necessary to understand human behaviour. He used the example of the act of winking to illustrate his meaning. In order to wink one must know how to do it and it is made a different act

from a twitch by intention. To use a wink for a purpose, one must know what winks can be used for and know that others will understand its meaning. The meaning of a wink is different in different contexts; cultural knowledge enables the meaning of the simple act to be both intended and understood. Thus, as Wolcott (1999) says, ethnography is "a way of seeing".

3.3.6 The theoretical underpinnings of ethnography

Ethnography has been influenced by a wide range of theoretical ideas, including realism and social constructivism, and much ethnographic research has been founded on interpretivist approaches (Hammersley, 2009), and particularly symbolic interactionism, the view that people's actions are guided by the meaning things have for them and that these meanings derive from social interaction (Reeves *et. al*, 2008). Whilst interactionism could have been an appropriate theoretical approach to a study of fathers' experiences on a children's ward, its focus is on collective behaviour and perceptions (Reeves *et. al.,* 2008). I felt a critical realist approach, with its emphasis on a stratified reality, gave the potential for greater ontological depth, to examine personal motivations and structural factors, in addition to collective behaviours and perspectives.

Historically, the classic ethnographic studies of early anthropologists were accepted as accurate representations of the societies from which they arose, representing "naïve realism", the view that social reality is there to be discovered as a truth (Mays and Pope, 2000). However with the progression of sociological thought during the twentieth century came challenges to this view which led to the crisis of representation and the crisis of legitimation within ethnography (Brewer, 2000).

The crisis of representation relates to the truth status of an ethnographic account. It arose from the anti –realist argument, arising from post-modern thought and relativism, that there is no external knowable world that can be studied or accurately represented (Brewer, 2000). Therefore all ethnographic accounts are constructions of the researcher; the phenomenon depicted is created in the text of the ethnography itself and does not therefore exist outside the text (Hammersley,

2009). From this perspective, the ethnographer's account is no more or less than valid than any other individual's.

The crisis of legitimation also arises from anti-realism. It refers to how and by what criteria ethnographic research should be evaluated (Brewer, 2000). Traditional criteria – validity, generalizability and reliability are based on realist assumptions which the anti-realist rejects (Brewer, 2000; Mays and Pope, 2000). However Brewer argues that in what he terms "post post-modern ethnography", the ethnographer can analyse and interpret data in order to give an accurate representation, providing sufficient evidence for others to assess that representation (Brewer, 2000).

Hammersley (1992) has proposed "subtle realism" as a way forward for ethnography- a third way between extremes of realism and relativism. A subtle realist stance is that phenomena do exist independently of knowledge of them, but recognises that knowledge is fallible and socially constructed, meaning that there can be multiple, valid descriptions of the same phenomenon (Hammersley, 1992).

Whilst Hammersley's "subtle realism" is initially appealing, I was persuaded by Banfield's argument that it is flawed (Banfield, 2004). Banfield argues that subtle realism is flawed because, firstly, it fails to make clear the criteria by which the validity of multiple descriptions might be judged; secondly, it is focused on epistemological questions and does not address ontological issues; and thirdly it does not give sufficient significance to the interaction between structure and agency (Banfield, 2004).

Few would now subscribe to a naïve realist view that ethnographic accounts represent reality in the straightforward way once thought, nor should the researcher's subjectivity be invisible within them.

3.3.7 Ethnography and critical realism

Although critical realism post-dates the development of ethnography, they are compatible (Porter and Ryan, 1996; Aull Davies, 2008). Whist other research approaches such as phenomenology would enable one to gain some understanding

of the "what" concerning fathers' experiences whilst their children are in hospital, this would not fully address my research questions as I sought to understand the "how" and the "why" therefore my research approach needed to reveal relational, structural and individual issues. As Porter and Ryan (1996) argue, critical realist ethnography enables the researcher to focus on wider issues of social structure whilst also seeking understanding of individuals' experiences. These may be unknown to individual participants. Therefore within critical realist ethnography, participants' own accounts are the starting point of the study, as the aim is to explain, not merely to describe, unlike in subtle realist ethnography (Sharpe, 2005).

The critical realist ethnographer also accepts the potential fallibility of knowledge claims and that knowledge is socially constructed. They also recognise the need to acknowledge the researcher's influence over the whole course of the inquiry through reflexivity (Brewer, 2000) (discussed further in section 3.8.1).

Aull Davis (2008) therefore suggests the aim is to produce an analysis of social reality *"that is outside the ethnographer, who was nonethess part of it"* (p254).

3.3.8 Ethnography in health care and nursing

Three central tenets of ethnography are naturalism, holism and culture (Laugherne, 1995). There is congruence therefore between these and nursing beliefs and values, which may explain the widespread use of ethnographic approaches in nursing and health care research. Savage (2006) argues that ethnography's simultaneous concern with the micro level of every day action and the macro wider context within which those actions occur makes it a highly valuable approach to health care research. She identifies a long tradition of ethnographic work in health care which has made significant contributions to modern day understandings. Savage (2006) asserts that ethnographic research is increasingly valued in health care, becoming more applied to the practical concerns of practitioners, their managers and policy –makers, yet that scepticism as to its value remains among those who fund health care research.

In examining the experiences of fathers when their child is in hospital, to understand what is happening and why, my aim has been to create thick

description. One has to spend time with the people concerned, observe and possibly share their experiences and talk to them about those experiences in order to obtain the emic view that is the goal of ethnography (Savage, 2006). The study thus comprises of: participant observation on a children's inpatient unit, interviews with fathers, interviews with nurses and consideration of a range of documents relevant to the unit. Thus this study is based on Wolcott's guidelines for ways of looking in ethnographic research: experiencing, enquiring and examining (Wolcott, 1999).

A further strength of ethnography is the capacity to respond to developing insights (Murphy and Dingwall, 2007). In ethnography, data collection and analysis are concurrent and each informs and is shaped by the other. Hence, during the study, the focus was modified in order to test early findings. For example, several nurses said that being a parent themselves benefitted their practice with parents. I subsequently specifically observed the practice of nurses who I knew to be parents in comparison with those I knew were not and was also able to question fathers about whether they thought there was a difference.

3.3.9 The study design

The study comprised participant observation on a children's unit over an eighteen month period, with semi-structured interviews with fathers and nurses using topic guides. Participant observation took place across the days of the week and at different times of day. Observation and interviews overlapped. Fathers were interviewed after their child's discharge; nurses were interviewed on the ward during quiet times or at the end of their shift. I also examined some elements of patient records, notices and other documents available on the unit.

3.4 LOCATION, ACCESS AND SAMPLE

3.4.1 Location

The study took place in the children's department of a district general hospital of an acute NHS Trust in a large town in the South of England. The unit consists of two inpatient wards, an assessment unit and day surgery unit. The study was focused on the two wards. Both wards receive unplanned admissions of children aged nought to sixteen years, with one receiving predominantly medical patients and the other predominantly surgical patients. The surgical ward also admits children for booked surgery although they were not included in the study as the focus was on unplanned admissions.

The geography of the unit

Each ward consists of three five-bedded bays and a number of cubicles. The wards are interconnected and share a four bedded high dependency area. There is also a shared playroom, ward kitchen, feed kitchen (both out of bounds to parents) and at the far end of one ward, a very small shared kitchen area for parents. This is the only facility specifically for parents. Each ward has a treatment room and various storage areas (out of bounds to parents). There is no waiting room. On each ward, families with children who are to be seen, assessed or waiting to be admitted wait in a row of chairs in a corridor. Access to the wards is via a swipe card system for staff; parents and visitors must ring a doorbell which is connected to a videophone and door release positioned at the nurses' station on each ward.

Parents who stay overnight are accommodated on folding beds alongside their child's bed either in individual cubicles (for babies under one year or children with infectious conditions) and in open four bedded bays. There is also a small resident parents' unit, consisting of two twin bedded rooms, separate from the main wards, across a corridor.

Staffing of the unit

The unit is staffed by trained children's nurses, support workers such as health care assistants, clerical staff, play therapists and teachers. Student children's nurses also have placements on both wards. The multidisciplinary team comprises paediatricians and their trainees, non-paediatric consultants such as orthopaedic surgeons and their teams and allied health professionals who visit as necessary. On children's wards parents are encouraged to be with their children throughout their hospital stay and siblings often visit for long periods, so each child may be accompanied by more than one family member. Consequently, children's wards in general are busy, socially complex environments, as were the study wards.

Rationale for choice of setting

This location has been chosen both for its typicality and because the experiences of families during a child's hospitalisation for acute illness has been overlooked. Most of the British studies discussed in chapter 2, outlined in Table 2.1, were conducted in children's hospitals offering tertiary services. Only one study has been identified which was conducted specifically with the parents of acutely ill/ injured children (Gasquoine, 2005), although this focused on mothers exclusively. The families in earlier studies therefore may have faced particular challenges such as having a child with a chronic illness, having a prolonged hospital stay, being a long distance from home or having a child requiring specialist treatment. Furthermore, the services and facilities for parents offered by tertiary units may differ from in the district general hospital.

Emergency admissions have always been a significant part of the workload on a general children's ward. In England there has been an 18% increase in emergency admissions of under-19's in the ten years to 2007, to in excess of 800,000 per year, with 58% of these coming through the emergency department and 24% through the general practitioner (Department of Health, 2008). Approximately 60% of the children admitted as emergencies are admitted under the care of a paediatrician with the greater part of the remainder being cared for by trauma and orthopaedic or general surgical consultants (Department of Health, 2008). Thus the work of the two wards is typical of the broader pattern of children's hospital care in England.

Given this pattern it is worth explaining why I did not include an Accident and Emergency Department. The focus of this study is on interactions between children's nurses who claim family-centred care as part of their professional philosophy and families. Within Accident and Emergency departments children are cared for by a mixture of staff, not necessarily a children's nurse. Much of the care delivered in Accident and Emergency is technical and relationships are brief so there may be limited opportunity to involve parents and develop partnerships. Therefore an Accident and Emergency department would not have been an appropriate setting to answer the research questions.

3.4.2 Access

Social settings may be considered as open (public) or closed (private) (Kennedy 1999). Gaining access to a closed setting, such as a children's ward, itself within the confines of a general hospital, needs to be planned and negotiated with gatekeepers. My access to the unit was negotiated through initial telephone contact with the clinical nurse manager of the unit, followed by face -to- face discussion with her and application to the Trust Research and Development Department. The study was also presented and discussed at one of the unit's scheduled senior nurses' meetings, organized by the clinical nurse manager. The clinical nurse manager can therefore be regarded as the gatekeeper for initial entry in to the field.

Sharkey and Larson (2005) maintain that gatekeepers are not neutral figures in the setting and can influence how the researcher is received. Fetterman (1998) advises that once access is obtained the researcher needs to establish their independence in order to minimize this influence. To this end I had minimal contact with the clinical nurse manager over the course of data generation.

My previous experience suggests that children's units are simultaneously open and closed settings, open in that a large variety of people pass through in the course of a day- a wide range of health professionals, support workers, other hospital staff, family members and other visitors. They are also closed- physically- in that the ward doors are often secure. The study wards were both physically and

organizationally closed, in that I had to gain an honorary contract with the Trust and undergo occupational health and Criminal Records Bureau screening to gain access. This process enabled me to acquire a symbol of belonging –a Trust identity badge, which also served as swipe card so that I could access the unit as I chose without having to ring a bell and wait to be allowed in as parents and other visitors do. Thus it both literally and metaphorically opened doors for me.

3.4.3 Sampling

Sampling in ethnography entails consideration of people, places, events and artefacts within the field of study (Agar, 1980). A purposive approach to sampling was taken, consistent with ethnographic research. That is, participants were approached because they had key characteristics of relevance to my investigation (Mason, 2002) and in order to maximise variation (Gobo, 2007), for example age of child and length of hospital stay (fathers) and years of experience and educational background (nurses).

People

Fathers

Table 3.1 provides an overview of the characteristics of fathers interviewed. Fathers present on the wards during observation periods were selectively approached and invited to take part in the study in order to achieve maximum variation in factors such as father's age, child's age and child's length of stay. The sample includes one father who was recruited via a request for participants posted on the Fatherhood Institute website who was interviewed by telephone and a further one recruited from personal networks. Data from these interviews provided a useful reference to practice and relationships beyond the two study wards. Both resident[1] (that is, staying overnight on the ward) and non-resident fathers were included. Hence the sample was purposive in providing the opportunity to explore whether fathers' involvement varied with paternal age, child age or length of stay. Given the discussion of changing fatherhoods in chapter 1, one might expect to see differences between younger and older fathers; child length of stay was a factor

[1] In this chapter " resident" is used to mean stayed in hospital overnight and does not refer to whether the father resided at the same address as the child

that emerged from the literature review as influencing parental involvement in care. As funding was not available for translation services, only those fathers who had sufficient command of English to be interviewed were approached. Possibly the experiences of fathers who were non English speakers could be very different from those of English speakers.

The sample was restricted to fathers of unplanned admissions in order to limit the scope of the study. Unplanned admissions represent the majority of childhood admissions to hospital so focusing on these increases the typicality of my study; the children of the fathers in the study included children with medical, orthopaedic and surgical conditions. A flexible approach to the definition of father was adopted. I planned to invite the "social" father (discussed in chapter 2) to take part. If children had both a social and biological father, interviewing both may have been illuminating and inclusive. I was keen not to marginalise a biological father who did not normally reside with the child, but also not to be dismissive of a mother's partner who lived with her children whilst having no biological or legal relationship with them. In reality, all the men who agreed to be interviewed were biological fathers and lived with their own children and the mother, some were married to the child's mother and others were not. Whilst in respect of co-residency with the child and mother, the participants are not representative of fathers as a whole, they may or may not be typical of those fathers who are present on a children's ward. Fathers living apart from their children or stepfathers –formal and informal- may exclude themselves or be more likely to be excluded from involvement in children's care.

Fathers interviewed came from diverse ethnic backgrounds, including white British, British born Pakistani, Indian and Black African, broadly reflecting the overall ethnic mix of the local population and fathers present on the ward. Given the small numbers involved, I have not given the specific ethnic background of individual fathers in Table 3.1 in order to protect participants' anonymity.

Table 3.1 Characteristics of father interviewees

Pseudonym	Age	Resident overnight on ward or not	Age of child on admission	Child's length of stay
Jake	24	no	11 months	4 days
Chris	42	Not applicable	10 years	daycase
Greg	43	yes	7 months	7 days
Yannis	35	no	8 months	5 days
Harry	40	no	16 months	6 days
Zack	34	yes	5 years	2 days
Ivor	33	no	3 weeks	4 days
Derek	39	no	6 years	24 days in two episodes
Adam	30	yes	5 days	24 days
Eddie	45	no	14 years	13 days
Barry	35	no	5 years	18 days
Frank	30	yes	7 weeks	7 days

Although Table 3.1 shows that fathers of younger children predominate, this was typical of the ward population. The majority of acute, unplanned childhood admissions are children under five years (DH 2008). The children of the fathers I interviewed experienced longer stays in hospital than is average on children's wards. In part I think this reflected a general tendency on the wards for children to stay in hospital for longer than in other paediatric units with which I am familiar, but it may also be that the fathers of longer-staying children were more ready to share their experiences with me.

Some fathers who declined to be interviewed did so because of their long working hours or because they did not know enough about the child, saying things like "you'd be better off talking to mum". Some said they felt had not been on the ward enough to have anything to say. Among the fathers I approached on the ward, this response was more common from those who were younger and/ or from lower socio-economic groups. Some fathers would have been happy to be interviewed whilst their child was an in-patient but did not want to be interviewed once the child had gone home.

Contacting fathers in writing after discharge was a condition of my ethical approval yet this slowed down recruitment into the interview element of the project. Early attempts to do so by letter proved completely unproductive, even though I was writing to men who had agreed to be interviewed already. I therefore used email. I was familiar at the beginning of the project with the notion that men are hard to reach as research participants (e.g. Doucet, 2006; Kirsch and Brandt, 2002), so whilst I was not surprised, I was frustrated and disappointed. Initially I used a student email address (consisting of numbers plus a suffix) to contact them with limited success. I found using a work email address which included my name increased the response rate.

Whilst it was challenging to recruit fathers to formal interviews, many were happy to talk to me informally on the ward, knowing that I was a researcher and was taking notes. I had numerous conversations with fathers during the course of observations so the study population of fathers is greater than those interviewed.

Consideration was given to including the mothers' perspectives in the study. My original decision was to omit them in order to begin to address the balance in the overall children's nursing literature on parents. However, I experienced maternal gatekeeping on several levels. I found, for example, that fathers who agreed to take part were more likely to follow through to interview if I made my initial approach when both parents were present. Some fathers gave their partners' email addresses as the contact point. I also realised that maternal behaviour was an important influence on paternal behaviour and that some women had important

insights to share. So whilst no formal interviews were conducted solely with mothers, three mothers did participate in the interviews and I have identified these as couple interviews. I also had many informal conversations with mothers which informed my analysis so maternal voices are, after all, reflected in this study.

Nurses

Selected band 5 and 6 staff nurses were invited to take part in interview. Nurses at these grades are qualified children's nurses who deliver and supervise day-to-day care on the wards to children and families. Those selected represented a range of ages, years of experience, educational level and came from a variety of initial nurse education backgrounds, see table 3.2. All were female and they were predominantly but not exclusively from White British backgrounds.

Table 3.2 Characteristics of nurse interviewees

Pseudonym	Age	Qualifications	Years of experience as a children's nurse
Una	30	RN Child BSc	7 months
Sam	49	RSCN BSc	20 years
Val	41	RN Child Dip HE	7 years
Tracey	27	RN Child Dip HE	7 months
Yvonne	58	RSCN	15 years
Zoe	23	RN Child DipHE	5 months
Wilma	47	EN RSCN Dip HE BSc	15 years

Places and events

Observation periods of 2- 4 hours took place over an eighteen month period, totalling in excess of 150 hours. I had free access across the unit. Observation was scheduled to encompass the range of activities, routines and rituals that occur across the unit during the course of the day and the week including ward rounds, nurse to nurse handovers, patient admission and discharges, although the greater part took place in the evenings and at weekends as this proved to be when greater numbers of fathers were present.

Documents

Documents are also a source of data for the qualitative researcher. Consideration of various documentary sources has been incorporated into the study. These include: the notices around the paediatric unit; information leaflets; nursing records; forms and thank-you cards.

3.5 ETHICS

Whilst Beauchamp and Childress' (2010) four ethical principles for research, namely respect for autonomy, non-maleficence, beneficence and justice were developed in relation to bio-medical research, Ipophen (2005) argues that they are equally important in health care. This study has been informed by these principles throughout, in design and practice. Mason (2002) argues that ethical decisions are always contextual and ethical qualitative research requires active moral practice on behalf of the researcher. Specific examples are given where relevant in the following discussion.

3.5.1 The process of gaining ethical approval

Ethical approval was sought and obtained from the local research committee of the National Research Ethics Service, in accordance with Department of Health Research Governance Framework for Health and Social Care (Department of Health, 2005). Minor changes to the information sheet and consent forms for nurses and fathers were required before final approval was given. Appendix 3.1 contains the notices, participant information sheets and consent forms used.

3.5.2 Confidentiality

In accordance with British Sociological Association guidance on ethical practice (BSA 2002), the anonymity of all participants has been maintained. Data have been stored on a password protected university server only. Pseudonyms have been used in all reports and publications; minor alterations have been made to some specific details in order to avoid any identification of the setting, individual children, parents, nurses or other person.

3.5.3 Ethics in the field

Consent

All research should be conducted on the basis that participants are fully informed about the overall purpose of the research and take part in the study on the basis of voluntary informed consent (BSA, 2002). Whilst formal written consent was obtained from nurses and fathers prior to interview, consent in the observation phase of this study was more problematic.

In a natural setting the researcher has little control over who does and does not become part of what is observed (Gerrish, 1997). It would be cumbersome, intrusive and impractical to obtain formal written consent from everyone who might be observed. Johnson (2004) agrees that ethnographers in complex social settings are rarely able to get written consent from everyone they meet. Carnevale *et. al.* (2008) recommend the strategy of seeking verbal consent where possible, providing written information in key locations and visibly differentiating the researcher from members of staff by not wearing a nurse's uniform.

Therefore the strategy adopted for this study was to display notices throughout the unit stating that research was taking place and that anyone who did not want to take part was free to refuse. All nurses on both wards were sent an individual letter explaining the study and that they could opt out (see appendix 3.1). However, staffing was not static for the duration of the study. If I became aware of new nursing staff members, a letter was sent to them, although bank nurses and nurses temporarily working in the unit were offered verbal explanations.

Whenever I approached parents, I would explain who I was and why I was there and ask for verbal consent before observation of any specific events or asking any questions. When I did, parents would often respond along the lines of "Oh yes, I saw the notice" which reassured me that my approach was effective, at least to an extent. However I did not directly seek consent from parents with whom I had no direct interaction, yet who appear in my field notes because, for example I noted an interaction between them and a nurse from a distance.

Written information (appendix 3.1) was given to the fathers whom I approached to be interviewed, with a tear off slip to be returned to me with contact details if they were happy to take part. This served as an expression of interest rather than a commitment to take part. They were informed of my independence from the hospital and that there were no repercussions if they declined and that they could decline at a later date. Fathers were then contacted to arrange an interview two-four weeks after discharge of the child. This allowed time for the child to recover and for the family to re-establish their routines at home. It also provided a cooling off period.

Written consent was obtained immediately before all interviews (appendix 3.1).

I adopted a style of dress consistent with other non-uniformed hospital staff and ensured my identity badge was always visible. This acted as a visual reminder that I was not there as a nurse and meant that I always had to explain my presence. Generally I was rarely challenged; if I was it was by a junior doctor or one of the housekeeping staff.

3.5.4 Safeguarding participants

An approach to safeguarding participants suggested by Carnevale *et. al.* (2008) is that staff should be able to use their judgement to designate certain children or parents as "off limits" to the researcher. In this study, families were approached only after confirmation with the nurse caring for them that it was acceptable to do so. There were occasions where due to the nature of the child's condition or social factors, I was advised not to approach certain families. The unit includes a high dependency area, where the most ill children are nursed. Observation was not conducted in this area where the children and families were most vulnerable, although fathers were approached once the children had improved and been moved to other parts of the wards. I also left the wards during any emergency situations as these were stressful situations for staff and families and not the focus of my research.

Furthermore, I used my nursing judgement to decide when to approach parents so as to be least intrusive. So for example, I did not approach a non-resident father

immediately after his arrival. Rather, I would respect the family's privacy during this important catching up time, nor did I interrupt family activities and games.

In this study, interviews with fathers were conducted at sites and times of their choosing. This was frequently in their home in the evening, but included a workplace and a railway station coffee shop. Manderson *et. al.* (2006) discuss the influence of place and its selection on the interviews, arguing that coffee shops and parks are anonymous spaces which may inhibit the discussion of sensitive topics whereas interviews in the interviewee's home alter the power balance whilst providing contextual information for the interviewer. I felt the two fathers who chose to be interviewed away from the family home were demonstrating their agency in managing the interview situation, keeping me distant from the family, but also exhibiting their confidence in talking about their experiences as fathers without the mother "on hand".

In terms of my personal safety, I left details of the person I was meeting and the location in an agreed place and made arrangements to contact a specific person at an agreed time.

3.5.5 Researcher-participant relationships

As participant observation entails prolonged engagement with the setting, the staff may cease to be aware of research taking place (Moore and Savage, 2002). Consent in such a study is therefore a continual process rather than a one off event. Murphy and Dingwall (2007) argue that consent in these circumstances is relational and sequential, based on trust between observer and participants rather than a contractual arrangement.

Relationships with staff

Pope (2005), who carried out participation observation in operating theatres, joining staff for breaks, adopted the strategy of openly taking notes as a visual prompt to those present to remember that research is happening. I too took notes openly as a visual reminder that research is taking place, but did not accompany staff on breaks as I felt this was overly intrusive. Similarly, I did not make notes of

when I saw families from the ward in the hospital coffee shop, when I was having a break.

Relationships with parents

In approaching parents both in the wards and later interviews I presented myself as a nurse teacher and researcher, stressing that I was not a member of the clinical team and my independence from the hospital, but that I was a children's nurse. Whilst this gave me an initial entrée with parents, my reflections on how this may have influenced the course of the study can be found in chapter 9.

Asking about fathers' experience of their child's hospitalisation is a sensitive issue. It involved them re-visiting difficult and anxious times. Johnson (2004) argues that although people may become upset during an interview, doing so in the presence of a nurse and receiving suggestions of where to go for further help may be beneficial in the longer term. Contact details for Action for Sick Children and the Trust Patient Advice and Liaison Service were available if fathers had concerns regarding aspects of their child's care that they wished to pursue. In the event, no fathers showed signs of more than brief, minimal upset, for example, a slightly longer pause in conversation or looking away from me. Whilst this may have been male stoicism in action, it was not possible for me to determine this and none wanted these contact details.

At the start of the study, my intention had been to speak to fathers only. During the course of some interviews, however, it became evident that three mothers also wanted to contribute. They loitered on the periphery, or interjected to "correct" a father's account, or a father would consult a mother during the course of the interview. Draper had similar experiences during her investigation into men's experiences during their partners' pregnancies (Draper, 2000). My response in the three situations where this happened, as a guest in their homes, was to accept mothers' participation in order to respect participants' autonomy, aware that this might nonetheless change the character of the interview, (see chapter 9 for my perceptions of this).

I also spoke informally to mothers alone during observation periods and couples together. I realised that parents experience their child's hospitalisation together and although the focus was on fathers, fathers' experiences were influenced by and influenced mothers (discussed further in chapter 5).

Relationships with children

As a children's nurse I thought very carefully as to whether I should ask for children's consent to speak to their fathers. This initially seemed to me to be the right thing to do, in accordance with respect for children's autonomy. The balance in children's rights is always between protection and participation. As the focus of the study is on acute admissions there were a number of factors to consider. The average length of stay for a child following emergency admission is 1.9 days (Department of Health, 2008). Children are discharged as soon as possible and are consequently still recovering when they go home. Also the majority of children admitted as emergencies are aged under five years (Department of Health, 2008), reflected in the ages of the children of fathers I interviewed. Therefore they would be unlikely to understand what I was asking.

I concluded that many children would be too unwell or too young to ask for consent and this might be intrusive or worry the children. I therefore decided against doing so routinely but prepared a notice specifically for children which informed them of the study and that they were able to decline to take part by letting their nurse know. Where there were older children or young people who were well enough, I asked them "Is it okay with you if I talk to your dad about what it's been like while you've been in hospital?" None refused or asked any further questions. Where younger children and babies were patients, I endeavoured to adopt a respectful approach, acknowledging them as persons, and with parental permission, speaking to, touching or playing with them. Interestingly neither the Research Ethics Committee nor Trust Research and Development Department asked for any discussion or clarification regarding children.

Reciprocity

As a nurse I am familiar with talking and listening to the parents of sick children and during interviews I was aware that I was asking fathers to share emotional events with me for a different purpose –helping me achieve a doctorate. I therefore felt an obligation to them to answer their questions honestly if they asked me any. Many did not, but a few did, mainly to do with my own circumstances such as whether I was a parent or not. Rarely I was also asked what I thought of the unit. I answered these questions honestly in general terms without comment on any clinical care.

I also asked fathers whether they wanted to receive a summary of my findings and agreed to feedback my findings to the Trust.

On the nurse researcher's professional responsibility

At all times during the study I was aware that as a registered nurse I had responsibilities in addition to the ethical behaviour expected of social scientists. I acted in accordance with the NMC Code of Conduct both in the hospital and when interviewing fathers. I was prepared to report any malpractice I observed although this proved unnecessary. There were times during data generation that I felt the researcher/nurse boundary was challenged and I reflect on this in chapter 9. I was not asked any clinical questions by patients or families at any stage during the course of the study. Had I been, these would have been referred to the clinical team.

I was also aware of my professional responsibilities with regards to child protection. I identified the contact details of the Trust's named nurse for child protection and would have reported any concerns to her had I had cause to do so.

3.6 DATA GENERATION

As my research questions involved examining fathers' involvement from their own and from nurses' perspectives in addition to the context in which involvement in care occurred, there was a need to gather data from more than one source and to use multiple methods of data collection (Mason, 2002). Within this study,

participant observation, semi-structured interviews with nurses and fathers and documents were sources of data.

3.6.1 Participant observation

Participant observation is the archetypal strategy in ethnographic research (Aull Davies, 2008). Traditionally within ethnography this has required the researcher to become personally involved with participants over a prolonged time (Aull Davies, 2008). Participation in the everyday lives of people provides the opportunity to: observe their behaviour; to observe events and engage in meaningful discussions with people (Aull Davies, 2008), thus enabling the researcher to collect multi-layered data on social interactions within context, rather than relying on retrospective accounts (Mason, 2002). Thus it is based on a naturalist perspective.

The challenge for the ethnographer is to achieve a role within the field that enables them to maintain a balance between participation and observation (Brewer, 2000) and which legitimises their presence in the setting so that they are accepted. Gold's typology of roles within participant observation suggests a continuum from complete observer through observer as participant, participant as observer to complete participant (Gold, 1958, cited by Aull Davies, 2008). However this view of participant observer roles as discrete and pre-determined is a little simplistic. Researchers may adopt different roles according to the particular circumstances, or may simultaneously hold more than one role -for example in relation to different groups within the field. Roper and Shapira (2000) argue that the specific role the researcher adopts should be driven by the needs of the situation.

Within participant observation therefore, the researcher is the main instrument of data generation (Brewer, 2000). Regardless of the level of participation, observation is inevitably partial (Mason, 2002). The researcher chooses what to pay attention to and what to record. Therefore it is important for the researcher to recognise their own biases, perspectives and the selectivity of their observations, thus the researcher is required to be self-aware and to examine the role they played in shaping the data. Similarly there is a need to consider how their presence influenced the events they observed- termed reactivity. Murphy (2005) argues that

reflexivity can help the researcher to identify, address and give account of these issues.

Participant observation and nursing research

Participant observation allows a researcher to view nursing actions and interactions in the context of preceding events and consequences, that is, practice as it happens (Bonner and Tolhurst, 2002) and to ask the practitioners about their reasoning and intentions. It has been argued that no other method can capture the complexities of nursing practice (Brink and Edgecombe, 2003). Kennedy (1999), using Carper's typology of nursing knowledge (1978) argues that nurses' personal knowledge is an undertapped resource for evidence-based practice and that ethnography is a method by which it can be accessed as it can accommodate the complexity of care, decisions and context.

Carnevale *et. al.* (2008) argue that participant observation can advance knowledge in this field by revealing information that cannot be gained in other ways but has been underused in research on children's healthcare. Of the literature reviewed in chapter 2, no studies claimed to be ethnographic, although several have used either observation or participant observation as part of their approach to data generation.

Roper and Shapira (2000) identify similarities between the ethnographic research process, particularly observation and interpretation, and the nursing process, arguing that nurses' professional skills equip them to be "natural ethnographers". Yet this is an over- simplification. Whilst nurses may indeed have many of the skills required by an ethnographer, they also need understanding of theory and method and preparedness to deal with the challenges arising from being a researcher-observer and registered nurse.

3.6.2 On being an insider/ outsider

A key issue for the qualitative researcher and particularly the participant observer, subject to intense debate in the qualitative research literature, is whether they are an insider or outsider in the social setting of their inquiry and what effect this has on their research. The insider researcher possesses prior intimate knowledge of

the community being studied and its members, thereby having privileged access to secret knowledge, whereas the outsider researcher's detachment from community members enables objectivity and the absence of pre-judgement (Labaree, 2002).

Styles (1979, cited by Hammersley, 2009) describes as a myth the view that only outsiders can conduct valid research on a given group, by virtue of their objectivity and emotional neutrality, and also the view that insider researchers present their own groups in a favourable light.

Hammersley (2009) suggests that whilst discussion of insider/outsider research as a dichotomy can be overly simplistic, it does have some value in the recognition that insiders and outsiders may have access to *different* kinds of information and face *different* methodological challenges.

The insider researcher faces a number of challenges. They may make assumptions and their perceptions may be clouded by their own personal experience (Corbin Dwyer and Buckle 2009). Hammersley (2009) argues that insider status can lead the researcher to fail to regard group members' perspectives as problematic and Corbin Dwyer and Buckle (2009) suggest that shared factors between researcher and participants can be given undue emphasis at the expense of discrepant factors.

A more nuanced understanding of insider/outsider status is given by Hellawell (2006) who argues that there are *"subtle shades of 'insiderism and 'outsiderism'"* (p 489). Gold's typology, discussed above can be seen as offering various shades of insider/outsider. Hellawell (2006) suggests an individual researcher can move backward and forward along a continuum of insider-outsider roles. Roper and Shapira (2000) argue that researchers need to balance their insider/outsider roles by establishing reciprocal and bounded relationships with group members and Hammersley (2009) argues that the researcher should seek to maintain a more or less marginal position which minimises the risks of over-rapport. Such marginality, however, creates uncertainty and is therefore stressful for the researcher (Hammersley, 2009). Walker (1997) uses the concept of "borderlands" in her discussion of marginality between the insider and outsider role and her position as both practitioner and academic, which has echoes of Corbin Dwyer and Buckle's

"the space between" (Corbin Dwyer and Buckle, 2009). It is in this "space between" that the ethnographer has both the closeness and distance to interpret their data.

Nonetheless there is also a need to lessen conspicuousness, increase rapport with participants and establish a normal role in the social context of the ward in order to minimise any effects of being observed, minimise disruption to the normal work of the unit and to increase the validity of data (Castellano, 2007).

There is a considerable body of literature examining the interface between insider and outsider roles for nurses investigating nursing and the dilemmas of nurses conducting participant observation of nursing, either in their own units or those where they previously worked (for example Kite, 1999; Bonner and Tolhurst, 2002) or as a nurse teacher undertaking research (for example Baillie, 1995; Gerrish, 1997; Hodgeson, 2001; Murphy, 2005). These authors all discuss the experience of being both an insider and outsider, of the tensions between adopting a nursing role and maintaining the focus on the research role, and in the case of nurse teachers, of being simultaneously a less than fully competent practitioner in nursing and a novice researcher. All emphasise the importance of fitting in for establishing initial rapport. However there is also a need to maintain sufficient distance to see the whole (Lykkeslat and Gjendal, 2007). Hodgeson (2001) sums this up as being "different, but at the same time within the context" (p 45).

Lykkeslet and Gjengdal (2007) suggest that the person researching their own culture is simultaneously blind and seeing. I have tried to minimise these problems by conducting this research in a unit with which I was previously only slightly acquainted, having visited only briefly on a handful of occasions. Arguably, previous knowledge may be an advantage in enabling theoretical sensitivity (Bonner and Tolhurst, 2002) and seeing beyond the immediate events to the subtleties of nursing practice.

My participant observation strategy

I held multiple and varied positions along the insider-outsider continuum during the course of the study. As I was interested in relationships between nurses and fathers, I tried to position myself between both groups, rather than adopt full

membership of one. As a children's nurse conducting ethnography in a children's unit, I shared a professional background with some of the participants and had some previous professional contact with a minority of the nurses. In my relationship with nurses, I was therefore a professional insider whilst being a social and organisational outsider. The researcher's role during participant observation is to fit in and act as naturally as possible (Armstrong, 1993), to cause minimal disruption and to minimise the effect of observation on people's behaviour. Whilst being a children's nurse enabled me to do this- I knew how and where to "be" on a children's ward, Armstrong (1993) cautions that familiarity with the scene may make the researcher insensitive to aspects which would be apparent to the less informed observer, so I was also aware of the need to be open-minded and tried to follow the data rather than my own pre-conceptions.

I chose not to work full shifts, which was impractical for me as a part time researcher and full time worker elsewhere. I therefore adopted a peripheral member researcher role without a functional role in the clinical team, as described by Fegran and Helseth (2009), and overall predominantly, but not exclusively, acted as observer as participant. Not being in the nursing team for a shift gave me the freedom to observe across the two wards, depending on what was happening, maximising my opportunities to observe nurses with fathers and fathers with children, although thereby limiting the depth of my understanding of nurses' experiences. I did not for example, have responsibility for patients nor did I experience the fatigue of a thirteen and half hour shift. Similarly I was not resident on the ward with a sick child.

Hammersley (2009) discusses the impact style of dress may have on the acceptance of the researcher. Therefore whilst not in a nurse's uniform I adopted my own "researcher uniform" so that I was always dressed in the same way, including during interviews with the fathers. This was intended to minimise my obtrusiveness in the setting, but also helped me, as a part time researcher, to assume a researcher role and identity, particularly in the early phase of the study, when I experienced the role uncertainties discussed by Baillie (1995), Kite (1999) and Murphy (2005) among others.

I found Johnson *et. al.*'s concept of a "culturally understandable identity" helpful in creating a role for myself as a participant observer (Johnson *et. al.* 2006). My name badge read "Research Nurse", the title the clinical nurse manager and I agreed. In introducing myself and my work I emphasised to nurses that I am a children's nurse. Hammersley (2009) has identified the importance of 'ordinary' topics of conversation in establishing the researcher's identity as a normal person. I engaged in "nurse-talk" with nurses which helped to establish rapport early in the study and also established me as a partial insider. The title "Research Nurse" also gave me an entrée into conversations with parents.

As a woman investigating fathers' experiences, I was evidently an outsider, yet at the same time as a parent I was not a total outsider. Furthermore, due to the rapid turnover of patients on the ward, fathers were also a quickly changing, transient group, so I would argue that there was no defined social community as such in which to be either an insider or outsider.

3.6.3 Field Notes

Field notes are an essential part of the ethnographer's data. In this study, field notes followed the structure suggested by Wallace (2005), a chronological record of observations, "head notes" – ideas, analytical thoughts, theoretical perspectives to consider, and jotted notes- brief hand-written notes made in the field, in conjunction with a research diary. Jotted notes were taken by hand contemporaneously with events (for example during handover), or shortly after. My position as observer as participant enabled me to disappear to a quiet place to write these. As observation periods sometimes lasted into the late evening, I ensured that fuller field notes were typed up by the end of the next day, in order to maximize my recollection. Observation notes were incorporated into the data set and included in the analysis.

In recording field notes, the subjectivity of the researcher comes into play. The researcher has discretion over what to notice, what to record and how to record it and Wolfinger (2002) argues that tacit knowledge influences these decisions. So

whilst I endeavoured to be accurate and honest in my field-notes and to focus on my research questions, they were inevitably influenced by personal factors.

3.6.4 Interviews

Mason (2002) argues that the qualitative researcher needs to consider to what extent their chosen setting will provide them with everything they need to know to understand the particular phenomenon being studied. A person's behaviour and perceptions at any one point in time are shaped by their previous experiences and future hopes and expectations (Sharkey and Larsen, 2005). With reference to my study, it is therefore evident that participant observation would not be sufficient to answer the questions. I conducted pre-arranged semi-structured interviews with fathers and nurses using a topic guide. However, in the manner described by Aull Davies (2008), I altered the sequencing and wording of interviews, sometimes omitting some which seemed inappropriate within a particular context. During the course of observations I also undertook unstructured interviews in the form of more casual conversations with a range of individuals, including mothers, fathers, other family carers, junior doctors, nurses, play specialists and domestic staff.

From a critical realist perspective, fathers' involvement in their hospitalised child's care has to be considered within the context of his broader family life and work. For example a father's expectations of his own role and nurses will be shaped by previous experiences with health care professionals (e.g. around the birth of the child), as well as his usual fathering role within that family. Similarly nurses bring their past experiences and own values and expectations to the interaction. Qualitative interviews can reveal the meanings everyday events can have for the people who experience them; people can explain the thoughts, feelings and motivations behind their behaviour (Taylor, 2005).

Interviews with fathers

Interviews were arranged by email after the children were discharged. Not all of those who agreed to take part responded to requests to arrange interviews, despite reminders. Two who had agreed to take part later declined interviews

because of their child's continuing health problems. I have no further information why others did not respond.

Audio-recorded interviews with fathers were conducted after the child's discharge from hospital, at a site and time of the father's choosing. Although this may have reduced the number of fathers agreeing to participate, it was an ethical strategy and enhanced the data from interviews as fathers were able to contextualise their experiences and had time to reflect on the meaning of their experiences. This is a point of difference between this study and the work of Darbyshire (1994) and Coyne (2003) who interviewed parents whilst their children were still in-patients. I felt that interviewing fathers whilst they were anxious about their child's well-being in hospital would have been intrusive and they would also not at that stage have had an overall perspective on the experience. It would have been difficult to find an appropriate location for the interview, free of interruptions.

Although interviewing fathers after their child's discharge presented challenges, I think it added to the strength of the study. With a little distance in both time and space from the immediate experience, fathers were able to contextualise the hospital experience within their broader family life. Several spontaneously mentioned pertinent structures such as their usual role in the family or their work patterns and how these influenced their actions in hospital. Fathers were not so focused on the immediacy of an event as they might have been in the ward environment.

All interviews began with one question which was accompanied with a topic guide, see appendix 3.4, which was used as a source of prompts if need be. The content of the topic guide evolved during the course of the study. For example, I was surprised when, during early interviews fathers focused on events leading up to the child being admitted to hospital. On reflection, I realised that this was in response to the word "admission" in my question. For me as a nurse, "admission" meant "hospital stay", whereas for fathers it appeared to mean "how the child came to be in hospital". I therefore revised the question, to "Could you tell me about your child's stay in hospital?"

Narrative interviews give participants more power as the participants control the story (Holloway and Freshwater, 2007), so fathers were asked to tell the story of their experience of their child's hospital admission, enabling them to determine the depth and detail they discussed.

Fathers chose the location for the interview and the majority chose their homes. I was therefore in the position of the guest and families were welcoming and hospitable towards me. Interviews can be regarded as social performances (Manderson *et. al.*, 2006) and I was often aware that fathers had staged their presentation of self, as indeed I did. Usually interviews took place in the dining room with other family members in the home but in another room. I presented myself as a children's nurse teacher and researcher, stressing that I was not a member of the clinical team and my independence from the hospital, adopting the persona of a sympathetic ally, as Draper (2000) described. I ensured I wore the same clothes as when I was on the ward as well as the hospital identity badge (see chapter 9 for reflections on this aspect of the study).

Sometimes children, particularly babies, were present during the interview; their vocalisations and parental responses to them feature on the recordings. These interviews were the least formal and most closely resembled ordinary conversations. On one occasion, the children of the family were presented rather formally to me at the end of the interview. I interpreted this as an emphasis by the father of his involvement with his family and an expression of paternal pride. For me, the presence of children was a validation of why I was there.

Interviews with nurses

Nurses were interviewed in a quiet area of the ward at convenient times during their working day. Semi-structured interviews were conducted in which the nurses were asked to discuss their experiences of working with fathers, again the topics covered evolved during the course of the study. In these interviews I attempted to down play my "nurse teacher" identity, aware that the interview could be seen as a sort of test, and tried to be an interested and supportive colleague. (Again, this is discussed further in chapter 9).

Documents

Documents are valid sources of data for the social scientist, in terms of their content, function and production (Prior 2003). Aull Davies argues the ethnographer considering documents should consider the text itself (what is said and not said); interaction (the relationship between author and audience); and the context (of their production and reception) (Aull Davies 2008). I have included a range of documents as sources as of data. Many notices, posters and leaflets were displayed around the wards, some aimed at staff, others at parents, and for others, the intended audience was unclear. There were also displays of thankyou cards from ex-patients and their families which I examined. I have considered some elements of nursing records. However I have not undertaken a formal ethnographic analysis of these documents, as described for example by Silverman (2001), nor undertaken discourse analysis or content analysis. Rather, I have sought answers to specific questions relating to their content, function and production, arising during the course of data collection, such as how father-child relationships were represented in records and why this was so and incorporated this information into the observation notes.

3.7 DATA HANDLING AND ANALYSIS

I transcribed all interview transcripts and field notes and although this was time consuming, it helped with immersion in the data. I read and re-read transcripts several times, checking initially for accuracy, then attending to content. Transcripts of interviews and field notes were then subject to a process of scrutinizing both manifest and latent content (Barton, 2008), using qualitative data analysis software (NVivo 8).

3.7.1 The process of data analysis

Qualitative data analysis is an inductive process, whereby the researcher moves from an initial focus on the particular through greater levels of abstraction

(Creswell, 2007). In ethnography, analysis is iterative, informing the progress of the study such as who to interview, what to observe, as it goes on (Fetterman, 1998).

Gobo (2008) recommends an analytical process for ethnographic data of:

deconstruction (exploratory, open coding);

construction (in which the story and hypotheses are developed);

and confirmation (in which the researcher checks the evidence for and against the hypotheses).

This is broadly similar to Brewer's (2000) two stages of analysis in ethnography. The first is a process of coding through content analysis through which data are organized into descriptive units, categories and patterns. The second is the interpretation of those patterns, attaching meaning and significance and explaining patterns, in which the researcher also challenges themselves to find alternative explanations (Brewer 2000). Richards (2009) recommends the following approach which I found helpful when carrying out the initial coding.

Noting what is interesting

Considering why that is interesting

Exploring why I am interested in that.

My approach was also informed by Bazely's suggestion (2007) to look for repetitions and regularities, asking questions, and comparing and contrasting segments of text.

I began analysis with immersion in the data through reading, re-reading and listening to the recordings. Hammersley (2009) cautions that it is important that the researcher's existing ideas do not become pre-judgements. Therefore, during open coding no theoretical framework was used as I was wary of making the data fit the framework or theory. Rather, coding was emic, although this process was inevitably influenced by my professional background and also the academic literature discussed in chapter 2. This may have led to foregrounding of some ideas. The result of initial open coding was a list of sixty codes which enabled me to see

the data as a whole and in effect provided a descriptive summary of the data. These initial codes were then reviewed, modified and combined to produce thirty codes, still descriptive but in slightly more abstract terms.

Obtaining a deeper understanding of fathers' experiences required the critical realist analytical process of retroduction, explained by Houston (2010) as the:

"inference from a description of a phenomenon to a description of something that produces it or is a condition for it" p.82.

Retroduction involves moving beyond the level of the empirical to identify the generative mechanisms behind events and experiences (McEvoy and Richards, 2006), or more simply put, thinking backward from effect to cause (Houston, 2010). So for example, some fathers' assertiveness with staff when they felt their child's care was not meeting the child's needs can be understood as deriving from their conscious or unconscious allegiance to protection of the child from harm as an element of the father role.

This process of ethnographic analysis, involving reflection, drawing on previous research and the critical assessment of competing interpretations (Hammersley, 2009) led to the development of categories. Some examples of the original data, coding and category are shown in appendix 3.5.

Having thus generated the categories shown in appendix 3.5, as a critical realist I sought to ensure that my categories did reflect the whole picture and that had I had captured the complexity of the social world. As such it needed to encompass micro and macro aspects of society, that is have ontological depth. Karp (2009) suggests a challenge in qualitative data analysis is to uncover irregularities while respecting the complexity and diversity of individual experience. Although I stress that my coding and categories were open and emic, I found Houston's domains of social life provided a framework to bring together the results of this process (Houston, 2010, see table 3.3). There is further discussion of this process and Houston's domains in the introduction to Part 3 which follows this chapter).

Table 3.3 Domains of social life (Houston, 2010, developed from Layder, 1997)

Domain of social life	Characteristics
The person	Deals with the embodied person, comprising physical, psychological, cognitive, genetic, existential and anthropological mechanisms
Situated activity	This is the sphere of "face to face" where social actions occur, meanings are attributed, and responses initiated according to these meanings. Underpinning these are mechanisms that preserve the social order.
Social settings	This is the institutional sphere comprising informal group settings such as family life but also the formal sphere of organizations. In these settings, mechanisms operate to reproduce social relations, positions and practices.
Culture	This is the sphere of "lifeworld" comprising norms, rituals, customs, tastes along with generative mechanisms that sustain meaning and social cohesion or else create division
Polity/economy	In this sphere, political and economic "system" imperatives are to the fore having great influence over the preceding domains

3.8 RIGOUR

Rigour and validity are important in qualitative research (Seale and Silverman, 1997). Whilst there is not a straightforward checklist by which this can be demonstrated (Barbour, 2001), Avis (2005) argues that the credibility of qualitative research rests on reflexivity, transparency and critical examination of findings in the light of any relevant theory. I have discussed earlier the particular challenges in relation to assessing the truth value of ethnographic research (see section 3.3.6). As

a critical realist, it is recognized that all knowledge is socially produced, whilst the relativist notion that all knowledge is equally valid is rejected (Porter 2007), therefore it is important to demonstrate the rigour of the research project undertaken.

Porter (2007) suggests the criteria to judge knowledge for social care, represented by the acronym TAPUPAS and devised by Pawson *et. al.* (2003), shown in table 3.4, provide a framework for readers to judge the knowledge claims of research. This model is compatible with a critical realist epistemology.

Table 3.4 Criteria to evaluate knowledge for social care (Pawson *et. al.,* 2003)

Criterion	**Question to be asked of the research**
Transparency	Is the process of knowledge generation open to outside scrutiny?
Accuracy	Are the claims made based on relevant and appropriate information?
Purposivity	Are the methods used fit for purpose?
Utility	Are the knowledge claims appropriate to the needs of the practitioner?
Propriety	Has the research been conducted ethically and legally?
Accessibility	Is the research presented in a style that is accessible to the practitioner?
Specificity	Does the knowledge generated reach source-specific standards?

In this chapter I have provided details to address purposivity and propriety; transparency and accuracy are addressed below and chapters 4-8 provide specific details to demonstrate accuracy. Whilst accessibility and specificity are for the reader to judge, this thesis has been subject to a process of writing and revision to render the work accessible and I have demonstrated through the use of theoretical sources that the research follows accepted standards.

3.8.1 Transparency

A reflexive research diary was kept in addition to field notes. This facilitates an audit trail of decisions enabling readers to recognise how the researcher arrived at

the findings (Holloway and Freshwater, 2007). I have outlined the rationale for some decisions I made during the course of the study in this chapter and further examples are given in subsequent chapters.

Appendix 3.5 provides a table giving exemplars of original data extracts, coding and how coded were grouped into categories to demonstrate the analytical process. Samples of coding were shared with my supervisors to increase the transparency and therefore trustworthiness of the study. During coding, data from different sources were coded to the same point, as appendix 3.5 shows. Whilst this is not triangulation in the quantitative sense, it does serve as confirmation. The mapping of categories onto Houston's domains is shown in Table 3.4. I acknowledge that Houston's domains – in separating out aspects of social life which in reality intertwine and overlap- are a simplification of the real world, but they do provide a model by which to structure my findings.

3.8.2 Reflexivity

In qualitative research, the researcher should demonstrate active reflexivity, that is, constantly scrutinise their own actions and role (Mason, 2002), challenge their own assumptions and examine how their own understanding has shaped their observations and interpretations (Avis, 2005). Reflexivity enhances transparency and this is seen as one of the elements of rigour in ethnographic research.

The critical realist ethnographer is conscious of the need for reflexivity, that is, to examine their own role and subjectivity in producing the ethnography, whilst being aware of a reality beyond themselves (Aull Davies, 2008). Reflexivity is the capacity to reflect on one's values and actions during the inquiry and consider how these influence the whole of the study (Arber, 2006). In this chapter I have discussed the influences on the methodological decisions made. I kept a research diary during the course of the study which enabled me to reflect further on the influence my subjectivity had on the study, the tensions I experienced as nurse and researcher and the emotions raised by my experiences. These issues are considered further in chapter 9.

I feel that as a female, I was able to be open to what the fathers said about their experiences – I did not have to bracket off my own interpretations to the extent that a male researcher might have had to do. As a nurse this was more of a struggle for me to achieve with the nurses. However, I had not practised as nurse on the wards in question so had not experienced the particular culture and demands of that setting, so I was not entering the field with specific pre-existing understanding.

Whilst I endeavoured to present myself as a 'sympathetic ally', as Draper (2000) describes, to all the participants, it is not for me to say whether I was successful in that.

In subsequent chapters my findings are related to existing theory and research findings.

3.8.3 Accuracy

One of the potential weaknesses of qualitative research is 'anecdotalism', that is, producing a partial, biased account based on short extracts from the data (Silverman, 2000). One way of addressing this is through deviant case analysis (Silverman, 2000). Throughout data analysis, deviant cases were sought. This is a process whereby the researcher intentionally looks for cases which appear to contradict the claims being made and seeks to explain these (Brewer, 2000). It can support the credibility of qualitative research by guarding against error and personal bias (Brewer, 2000). An example is where the experiences of two fathers who discussed genuinely collaborative relationships with nurses were considered more closely. Both fathers had attended hospital with the child but without maternal presence at all during the child's stay, thus revealing that nurses *do* involve fathers and respect their expertise *if a mother is not present*. Similarly cross-checking developing interpretations during the course of the study enhances reliability (Aull Davies 2008). So when for example, several nurses mentioned that they felt being mothers themselves enhanced their practice with parents, I followed this up in father interviews and by direct observation of the practice of nurses I knew to mothers and those I knew were not. (I reflect on this aspect of the study in chapter 9).

I have explained the variety of sources of data used in this study. Silverman (2000), however, cautions against using multiple methods of data collection in an attempt at triangulation, arguing that the truth status of different types of data may not be compatible. Therefore he argues that evidence from different sources cannot simply be mapped as if they were the same. It seems to me, however, that critical realism can accommodate evidence of different sorts in a bid to understand a whole picture with each of them pertaining to a different aspect of the reality of a YUsituation. For example a personal motivation described in interview (empirical reality) can be related to observed actions, records made (empirical and actual reality) and structural factors (causal reality).

Findings during the course of this study have been shared with academic experts in fatherhood and third year student children's nurses who found them to be plausible.

Respondent validation, the process of returning to participants with a summary or interpretation to confirm whether it truly represents their experience is argued by some to enhance the trustworthiness of qualitative research (Holloway, 2005). This process was considered but not performed for this study. One question that arises is what one should do if a respondent's interpretations differ from the researcher's. If the researcher accepts them at face value, this undermines the whole research process and could lead to collusion (Barbour, 2001). Ryan-Nicholls and Will (2009) and Barbour (2001) argue it may be more trouble than it is worth in one-off health research. Bloor (1978, cited by Silverman, 2000) has questioned whether lay respondents can comprehend a report written for a sociological audience. However a summary of findings will be provided to the hospital trust and fathers who expressed an interest in receiving one have also been sent a summary of findings.

Further, the value of respondent validation has particularly been questioned in ethnographic research. In critical realist terms, participants would have access only to their own empirical reality; actual reality is greater than one individual's experience and participants may have limited awareness of causal reality. Gobo

(2008) argues that it is not a means to evaluate the scientific validity of an ethnographic account.

3.9 CONCLUSIONS

In this chapter I have explained and justified the philosophical underpinnings, design and conduct of my study. I have argued that ethnography enables the researcher to capture the complexity of social worlds and that critical realism provides an ontological, epistemological and methodological basis for the study.

I have also identified key challenges, changes and decisions as the research progressed, providing along the way what Silverman (2000) terms a natural history, rather than a sanitised account. I have also established the measures taken to enhance the trustworthiness of my findings.

As a woman, I cannot achieve an insider's view of fathers' experiences and do not claim to have done so. Rather I have gained glimpses of the social world of the children's wards from three perspectives- fathers', nurses' and my own.

My findings are presented in the following five chapters, each of which focuses on one of Houston's domains of social life (Houston 2010, shown in Table 3.3).

PART 3

Introduction to Part 3

I.1 THE PROCESS OF ANALYSIS

Ethnographic analysis involving interpretation and the search for meaning can be subject to false starts, and so I found during this inquiry. Initially, I considered a thematic analysis yet found this to be focusing exclusively on fathers' perspectives. I also considered using a model of father involvement, such as that discussed in chapter 1 by Flouri (2005). It seemed to me that with either of these approaches incorporating themes from nurses would have created disjuncture. Another strategy I considered was to identify key events in the child and family's journey (a diagram of which is shown in figure 6.1), and analyse fathers' experiences at these key points.

I was seeking to incorporate data from a range of different sources, giving equal weighting to these different sources. As a critical realist I was seeking not just to describe but to explain and could see that my coding and categorisation were showing personal, familial and institutional factors having an impact on fathers' experiences, reflecting a stratified social world. Therefore, *only after* categories had been determined, I made the decision to map my categories, derived from an open, emic coding process, onto Houston's domains of social life. I found that all of my categories mapped and that all of the domains had categories mapped to them without any adjustments. This mapping is shown in table I.i.

This process assured me of the ontological depth of my analysis. Houston's domains also enabled me to see how the categories related to one another, but also how the very strong themes relating to the father role of protecting, providing and participating were present throughout the domains, yet influenced by factors within them.

Table I.1 Mapping of categories to Houston's domains of social life (Houston, 2010)

Category	Domain
Being there	Domain of the person
The emotional experience	
Coping	
Fathers' agency	
Mother-father relationships	Domain of situated activity
Father-nurse relationships	
Nurses and parents as co-workers	
The family	Domain of social settings
The institutional processes and routine of the paediatric unit	
Prioritising the maternal	Domain of culture
Masculinity and femininity	
Parents work	Domain of polity/economy
The influence of work on fathers' experiences	
Understanding nursing as work	

1.2 DISCUSSION OF DOMAIN THEORY

Houston's domains of social life (Houston, 2010) indicate how human agency (such as reasons and motives) combines with unseen social forces (such as gender) to produce effects in a multi-layered complex social world. Houston's model of five domains is based on Layder's original domain theory in which Layder proposed four domains: psychobiography, situated activity and contextual resources, encompassing cultural and material dimensions (Layder, 2006). Houston, however has argued that a domain of the person is a more complete conceptualisation than psychobiography because a domain of the person includes an embodied, physical self, not just a psychological self (Houston, 2010). Similarly Houston (2010) argues that the two dimensions of contextual resources in Layder's domains, namely cultural and material, are sufficiently different to be considered as two separate domains, hence Houston's five domains.

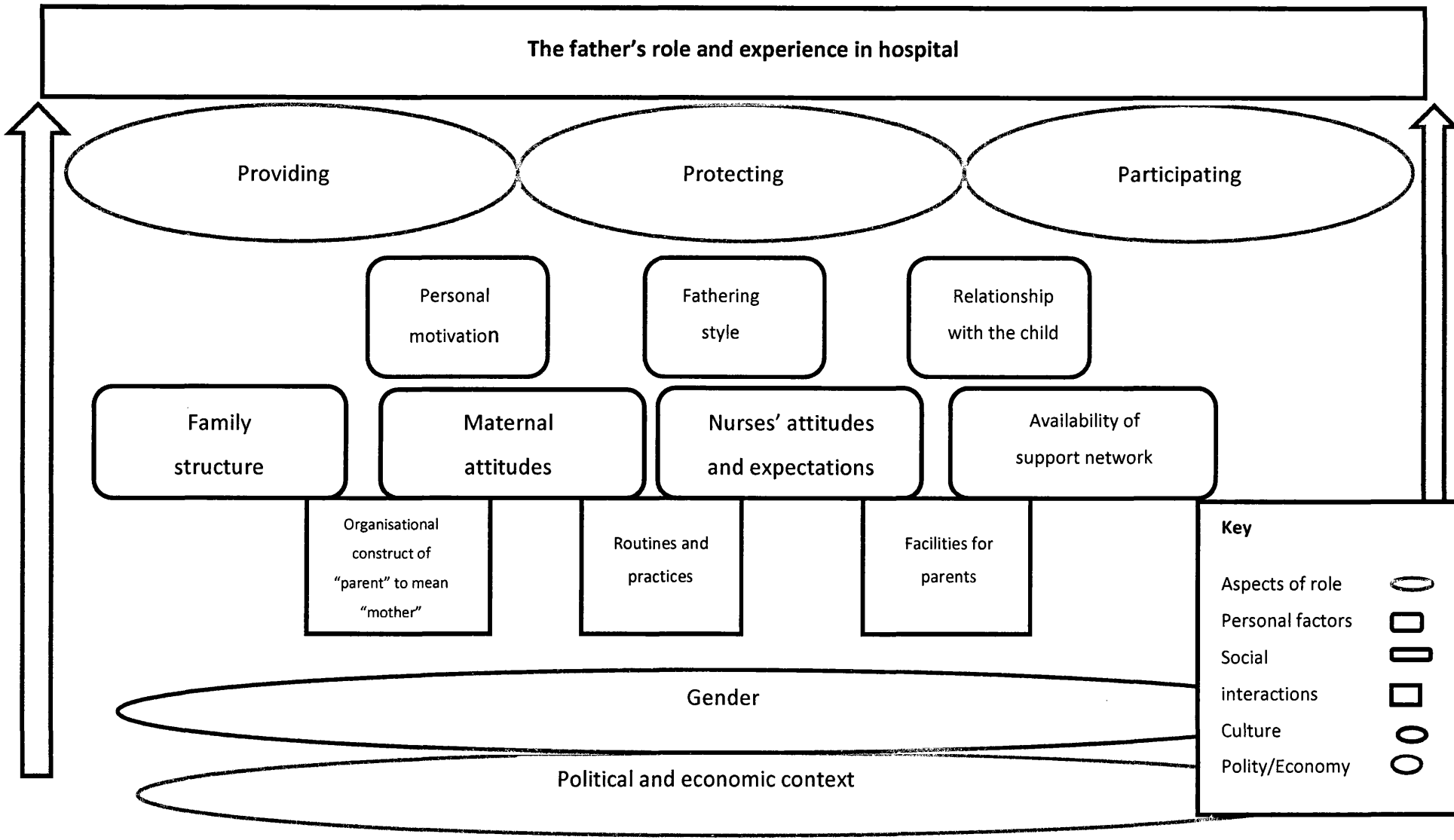
Leberman and Palmer (2009) have argued that domain theory provides a means of addressing the apparent divides between personal/ context, micro/macro and agency/structure. However, it must be said that the individual does not experience daily life in the stratified way suggested by the domains, even though their life is shaped by them (Carter and Sealey, 2000). Therefore the domains may have little immediate resonance with participants in the study.

Furthermore, few researchers have used domain theory, and those that have are in the fields of socio-linguistics (Carter and Seale, 2000), sports studies (Leberman and Palmer, 2009) and information systems (Carlsson, undated), although Houston has used his own model in the field of social work. Therefore domain theory in general and Houston's model in particular are untested as frameworks for nursing research. Yet I have found Houston's model an accessible framework which reflects the complexity of what I found and provided a structure by which my findings could be presented in a way that captured more of the totality of fathers' experiences than the alternatives discussed above.

I.3 A MODEL OF FATHERS' EXPERIENCES DURING THEIR CHILD'S ACUTE HOSPITAL ADMISSION

It is necessary to disentangle multiple strands of social life in order to make analytic sense before re-integrating into a whole ethnographic account (Hammersley, 2009). Reflecting on the relationship between the elements of father role and these domains led me to the development of a model of fathers' experiences during their child's acute hospital admission. This is presented in Figure I.1 and represents a summary of my interpretation of how dimensions of fathers' roles interact with elements from within the social domains, incorporating therefore the individual father's psychobiography and broader social factors. Whilst protecting, providing and participating were universal among the fathers interviewed, the significance, priority and time given to each dimension by an individual father varied according to his own values, desires and circumstances.

Figure I.1 Influences on fathers' roles and experiences during their child's hospitalisation



The understanding presented in Figure I.1 is partial and a consequence of my own subjectivities as a researcher. However chapters 4-8 provide the evidence which contributed towards this interpretation, so that other may judge the reasonableness of my interpretation and figure I.1 is provided as an initial representation, for future development and critique.

I have structured the detailed findings according to the social domains, and within each referred to the dimensions of fatherhood where appropriate. One must also bear in mind that any written account is a result of textualisation- the attempt to express embodied experiences, observations, reflections and understandings in words (Aull Davies, 2008).

In subsequent chapters, all participants' names and some minor details have been changed to protect participant confidentiality. For a similar reason, I have not given details of any individual participant's ethnicity.

Chapter 4 The domain of the person –being a dad on a children's ward[2]

4.1 INTRODUCTION

In this chapter my findings in relation to the domain of the person are presented; this domain relates to the embodied person and is therefore concerned with the physical, psychological, cognitive self and agency, not just in the present but recognising the influence of past experience. Within this chapter, findings relating to the categories of being there, the emotional experience, coping and fathers' agency are discussed.

4.2 BEING THERE

The notion of "being there" occurs in the literature on parents of ill children (for example Coyne and Cowley, 2007) and in relation to fathers of children with cancer (Kars *et. al.,* 2008). It encompasses both physical presence and a sense of emotional commitment ("I won't let you down") and has been described as "the heart of parenthood" (Kars *et. al.,* 2008, p. 1557). In this section, my findings relating to fathers' physical presence and contact, fathers' assumptions around parental presence, and fathers' experience of the need to "be there" with the ill child are presented.

4.2.1 Physical presence and contact

Over the course of my visits to the unit, on few occasions were no fathers present on the wards at all. Although a greater number of fathers were present in the evenings and at weekends, regardless of the time of day or day of the week, fathers were around on the wards. Each time I visited the wards I undertook a headcount of the number of fathers present at a particular point and noted the ages and sex of

[2] The use of the term "dad" for this chapter heading reflects the language used by participants, although it is acknowledged that it not a term which is used universally to mean "father".

the children they accompanied. There was no difference identified in rates of father presence in relation to the sex of the child. Table 4.1 shows details of father presence across some observation periods.

Table 4.1 Parental presence at random headcounts during the study

Observation period	Time of day	Number of children on ward	Number of fathers on ward	Number of mothers on ward	Number of children without a parent with them	Number of fathers on their own with child
3	0715	12	3	9	2	1
4	0700	11	3	7	2	2
5	1300	7	4	6	0	1
6	1730	6	2	5	Grandparents with one child	0
9	1000	11	0	10	1 with grandmother	0
12	0800	15	1	9	5	1
13	1300	15	4	10	2	3
14	0650	17	0	16	1	0
15	0915	15	2	11	2	1
16	0700	10	2	6	3	1
17	1300	10	5	5	2	3
18	0930	11	3	5	1	3
19	1000	14	5	11	0	3
20	1100	11	2	9	2	1
21	0650	12	2	7	5	0
22	1430	14	2	7	6	0
23	1200	11	5	9	1	1
27	1030	10	4	5	2	3
32	1630	11	5	6	4	1
36	2030	10	3	4	5	1

Figure 4.1 shows the overall proportions by age of children whose father was present on the wards at the time of the headcount across the period of data collection. This figure does not relate to fathers staying overnight- rather just those present on the ward at the time I undertook the count, whether or not the mother was also present. This figure clearly demonstrates that the significant majority of father presence related to children aged less than 2 years. Whilst this age group also represented the majority of patients on the ward on the majority of my visits, there may be a number of societal reasons why fathers of under 2s were on the ward more than fathers of older children:

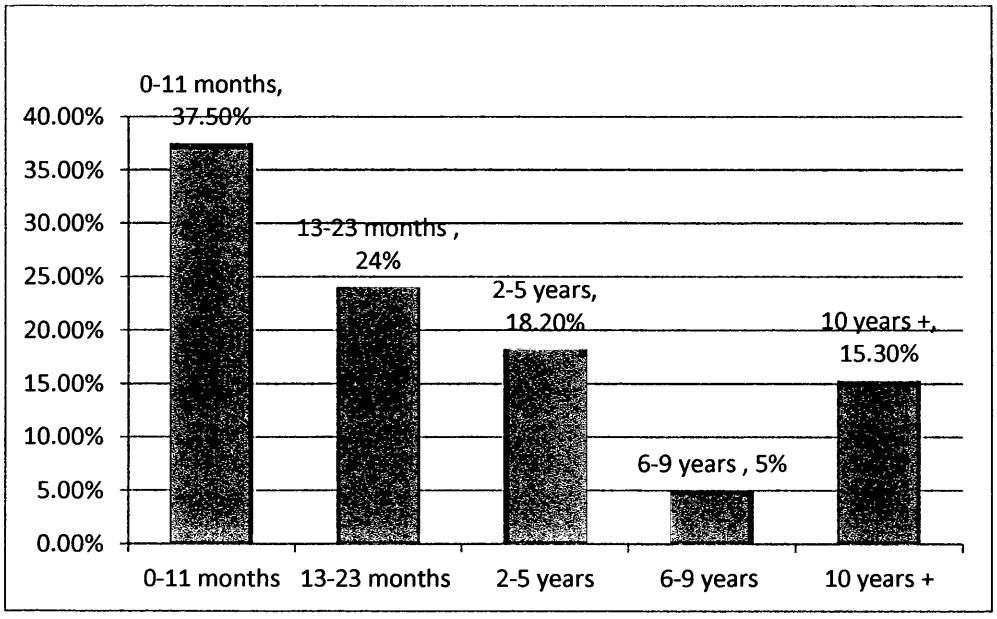
fathers of younger children may in general be more involved with their children's lives;

fathers of younger children may relate more to the model of involved fatherhood or co-parenting;

fathers of younger children may be less likely to have other children and therefore may find it easier to be present;

the availability of paternity leave may have enabled more fathers of very young babies to be present on the wards.

Figure 4.1 Proportion of fathers present on wards by age of child



Thus while physical presence lies within the domain of the person, it is influenced by factors from the domains of situated activity, social settings, culture and polity, reflecting the complexity of daily life.

Some nurses were convinced that they had seen an increase in the number of fathers being on the wards and staying overnight with their children in recent years, whilst others did not feel that that was the case.

"I would say ... most, well not most, but a lot of fathers do stay and are supportive but, they'll stay all day and they'll take their turn like looking after them at night. " (nurse interview Yvonne)

"but there is an increase in fathers being in hospital- or I've seen it here, on this ward, this acute setting, definitely there's an increase" (nurse interview Val).

"I think that there are less dads on the ward really. The people who tend to stay are the mothers so you don't get a ..lot of opportunity to work with dads really." (nurse interview Zoe)

"It's that not that many dads do the nights" (nurse interview Wilma).

These extracts from nurses reveal not only different beliefs and perspectives on paternal presence, but also the significance they attributed to fathers being resident on the wards overnight as an indicator of fathers' commitment to their child.

Historical data is not available as fathers have been overlooked in earlier research so it is not possible to say definitively whether more fathers are spending more time with their children in hospital than in the past or not. However the very small numbers of fathers in earlier studies of "parents" (for example Darbyshire, 1994; Callery, 1995) does suggest that fewer fathers were present on wards for prolonged periods in earlier decades than was the case during this study.

Physical contact between parent and child is one way that "being there" is expressed. Fathers who were present on the wards, particularly those of younger children and babies were observed seeking physical contact with their children – holding their hands, cuddling them and carrying them around. Fathers in interview also frequently spoke of the importance of touch.

"She was up to the machines and she had oxygen so she could only go from her cot to the chair next to her, so I was just holding her" (Jake, father interview)

Wolff *et. al.* (2010) have suggested that the physical attributes of fathers, such as size, strength and deep voice may in themselves create a greater sense of security for some children, whilst recognising that not all men are bigger and stronger than women, so paternal physical contact with the child may represent an embodied aspect of the paternal protective role, in addition to being an expression of care.

4.2.2 Constant parental presence

A constant parental presence on the ward was assumed by nurses and the majority of parents.

"there wasn't really any question about us not being there...no, so that was that, about three weeks –well twenty-four days later, we went home (laughs)" (Adam father interview)

Whenever I visited, children without an accompanying parent were a minority. Usually those who were unaccompanied were very young babies, teenagers or children with cognitive impairment with very complex needs. When children were unaccompanied, the reasons would be given in handover, for example an explanation would be given that the mother was unwell or was single and had other children with no other family members to care for them.

I frequently observed a father arrive on the ward followed shortly after by the mother leaving the ward, so that the child was never alone. Fathers saw their role as contributing to this constant presence, sharing the responsibility with mothers, frequently talking of "doing shifts".

"each day my wife would look after her during the day and I would come about 6, to look after her overnight" (Greg, father interview).

Fathers who were not resident overnight saw themselves as contributing too.

"well throughout the night I was getting the kip that I could so in the day when I returned Sam could have a break" (Jake, father interview)

Nurses expected fathers "to do their share" and contribute to this twenty four hour presence.

"they'll stay all day, they'll take their turn like looking after them at night. So Mum will here all day and dad will come and do the night shift and they'll swap over" (Yvonne, nurse interview)

Grandparents also contributed to this constant presence, enabling both parents to leave the ward together.

"mother and grandmother have arrived on the ward, join the father and child in the playroom, mother and father leave the ward shortly after, leaving child with grandmother" (Observation notes 22)

The importance of grandparents' contributions to family life in general has been recognised in recent years, although their contributions to the care of the acutely ill child are yet to be explored.

Unlike in Coyne and Cowley's research (2007), parents in this study did not express a compulsion to be present because of doubts that the child would be cared for adequately if they were not.

"I think if it happened again because we liked the thought that he was never on his own, at the hospital. And it's not because we didn't absolutely trust the nurses and the doctors who were looking after him, it's just that we were.. we wanted to be there for him, close to him" (Adam father interview)

4.2.3 The emotional need to "be there"

The parental need to "be there" for the ill child in hospital is apparent in research conducted almost exclusively with mothers or where they were a significant majority of the sample (Darbyshire, 1994; Callery and Luker, 1996; Coyne, 2007; Coyne and Cowley, 2007). So whether fathers experience the same need to "be with" their acutely ill child, and if so how they respond to the tensions arising from this need and other responsibilities such as caring for other children and work demands, have not been considered in earlier research.

During interviews for this study, the majority of fathers, including those who did not stay overnight, spontaneously expressed the need to be there with their child in hospital, even though this was an emotionally challenging experience.

"I guess but still there because I had to be there but it was a horrible evening I think" (Frank and Tara, couple interview, stayed overnight)

*"I can't imagine Billy being there, spending all those days by himself" (*Barry, Barry and Ali, couple interview, did not stay overnight but stayed throughout each day of his child's prolonged stay)

"I think one of the difficulties I had was that Lucy, we wanted her to go to sleep about 7 o'clock, half past seven, so.. and I didn't really want to leave her side ....

...and I wouldn't want to choose any other place to be because I wanted to make sure she was okay so" (Greg, father interview stayed overnight)

"So it's always hard leaving and kind of leaving your family there and going home so, one – you know you have to because although we don't have any other children, we have a dog at home so you still need to go home and take her out, but yeah you kind of, don't really want to leave and you sort of want to get back as soon as possible but when you're there it's kind of... you just lose days because you don't really have time to do anything properly because you're rushing to get back to the hospital and you , which sounds silly but then you don't want to leave at the end of the day" (Ivor, father interview, did not stay overnight)

Some stressed that this need was not because they did not trust the staff or felt that their child was at risk, but was a more existential need.

"We chose to be there as much as we did. We didn't have to be in terms of his safety point of view. We weren't worried about that" (Adam, father interview)

And Chris, who had been a very fluent and prepared interviewee, hesitated for the first time during the interview when talking of leaving his child in the anaesthetic room:

"I did find it incredibly difficult ***to... leave.. her there"*** *(*Chris father interview)(his emphasis)

Thus it would appear that some fathers, at least, experienced an emotional need to "be with" their child and were willing to talk to me about in those terms. Yet their agency towards fulfilling this need was often inhibited by several factors:

the perception of several of them that they experienced this need with less intensity than mothers did (discussed further in Chapter 5);

the institutional culture and rules (discussed further in Chapter 7)

and structural factors (discussed further in Chapter 8).

My interpretation was that in discussing this need with me they were demonstrating their commitment to being "involved fathers" and also performing the protective element of the father role, whether consciously or unconsciously.

4.3 THE EMOTIONAL EXPERIENCE

Parents' emotional state during their child's stay in hospital influences their capacity to provide emotional support for their child (Melnyk, 2000). During interviews many fathers openly discussed the emotions they experienced during their child's stay on the wards and others exhibited emotions behaviourally- several became hesitant, spoke very quietly or looked away briefly at emotionally laden

moments in interviews, in contrast to stereotypical views that men are reluctant to show emotions.

Fathers described just being on the ward as "draining", even once the initial uncertainty about their child's condition had passed.

*"it was just, emotionally and physically I was just drained I guess" (*Frank and Tara, couple interview)"

*"it was so tiring really being at the hospital, mentally draining"(*Adam, father interview)

"And the problem I guess with children's wards is there's a lot of sick kids there and it's just not a nice.. not something I see day-to -day at all. So when you see it all the time and you're in there too.. I don't know.. I found it pretty emotionally draining really..." (Frank and Tara, couple interview.)

Emotions identified by fathers included: uncertainty, stress and anxiety, the need for reassurance, feeling powerless or in control, anger and frustration and also functioning on "autopilot". Two further aspects of the experience which influenced fathers emotionally were waiting and their child having to undergo painful procedures.

4.3.1. Anxiety, stress and uncertainty

Anxiety and uncertainty were key features, particularly during the early hours after the child's admission, when diagnoses were still not known. Given that the focus of the study was on unplanned admissions, this in itself was not surprising, but for families, admission occurred after a preceding period of uncertainty which commenced when parents had first recognised their child was ill and then sought help.

"So it was a bit of a whirlwind day to get there.. and then, when we got onto the ward, it was, it just felt a little bit... lost, cos we came onto the ward having not really expected to be there and then were just sort in a room on the paediatric ward" (Ivor, father interview*)*

*"my wife and I – it's our flesh and blood so we really didn't know – it was quite a scary time really" (*Greg, father interview*)*

So whilst admission to the ward on one level was seen as a relief because the child was in a safe place, it was also the start of another, sometimes prolonged, stressful experience, when parents were uncertain about the outcome.

"so. .to stay there overnight for the first night was in my mind absolutely fine 'cos I thought we were going home the next day. So to then find out we were going to be there for five more days or a

week... it was .. a bit of a nightmare, a nightmare with work.. with him.. with everything." (Frank and Tara couple interview)

"So really the immediate pressure came off fairly quickly actually once coming out of the HDU onto the ward cos we felt that he wasn't going to die which we felt he might well do for the first two nights..." (Adam, father interview)

Harry, speaking of his work colleagues whilst his daughter was in hospital said:

"I was .. under intense .. stress. And it's not.. something.. they'd never seen me ..it's not something they've ever ..seen me ..ever professionally. And they've known me seven years, I've been there seven years so and that was the first time that I'd come into an office with.. a.. an emotional angle to me" (Harry father interview)

I felt that he himself had been surprised by the intensity of his emotional reaction to his daughter's illness and how he had been not been able to prevent this from becoming evident in his workplace.

Some nurses in this study felt that fathers experienced more stress than mothers:

"The difference is um I find the fathers can, um, I find them very much more tense...But there are um you know there are the minor few very laid back but they are much more tense than um er how to say it I guess they're more worried, because the mum's with the child most the time" (Val, nurse interview)

Feelings of loss or uncertainty in relation to the parental role have been identified by both parents and nurses as sources of parental stress in other research (for example Coyne and Cowley, 2007), yet was not identified by fathers in my study. Research by Graves and Ware (1990) revealed that fathers' and mothers' ratings of specific stressful hospital –related events differed. They also identified significant differences between how healthcare professionals and parents rated these events, with greater differences between female nurses and fathers and male paediatricians and mothers, suggesting that health care professionals have limited insight into parental perspectives, which is compounded by gender difference.

4.3.2 Anger and frustration

Some fathers reported feeling angry or frustrated. These emotions arose from what was seen as indecision or inconsistency on the part of doctors, and was never expressed in relation to nurses.

"One o'clock it was before we actually saw the doctor but by that time I mean, I'd been up all day Daphne [daughter] *had been up all day, Philip* [son-the patient] *had been up all day and I was getting a little bit annoyed, angry because it was now getting to a point where he needs to go to bed, Daphne needs to go to bed. We'd been up all day and they just seemed to drag their heels*

about what they were going to do and everything else. And then in the end they, I think it was about half past twelve or quarter to one they said "Oh he's staying the night" and I just was starting to , my blood was starting to get up on myself and I was, and the noise. So I was getting angry because no-one was making a decision so you know" (Derek, father interview)

*" So I start getting annoyed again because he's hungry, he's thirsty and everything so, and they just kept, they'll be here shortly, be here in a bit, be here in a bit so it got to 8 o'clock at night and I went up to one of the nurses and I said, I want a decision" (*Derek, father interview)

*"we tended to see a different doctor or registrar or consultant , whoever they were, and they'd all say different bloody things so one bloke said yeah you can go home in the next couple of days and the next one would say no you won't but we can give you ward leave. So what's going on?"(*Frank and Tara, couple interview)

So fathers' anger and frustration was expressed largely in relation to doctors, rather than nurses, and what fathers perceived as inconsistency or indecision, but also as a result of feeling powerless within the situation. McGrath and Chesler (2004) found fathers of children with cancer experienced anger from loss of power and inability to control the situation. Thus anger could be seen as arising from perceived challenges to fathers' protective role. However fathers, mothers and nurses suggested that mothers could also experience frustration as a result of waiting for aspects of care to be done by nurses.

"when my daughter needed a change in the saline drip or something...it hadn't been changed and had been beeping for a long time..the missus was quite frustrated.. and did tell the nurses that she keeps waiting" (Harry, father interview)

"I've had some mums that have found waiting for certain things as quite testing on them so they've got quite frustrated" (Una, nurse interview).

Gender may thus be exerting an influence on how and towards whom anger is expressed and framed- that fathers could feel and express anger about indecisive male consultants and mothers could feel and express frustration about unresponsive female nurses.

This scenario below provides an example of how nurses actively but unconsciously managed fathers' protective agency.

"A nurse is talking to a father on the phone – she explains to me later that he is a local resident but his daughter is in hospital in another town because of the lack of beds. She perceived that he rang the ward to try to pressurise the ward to take her. This had been discussed earlier and several other patients are also waiting for beds on the ward so consultant and senior nurse were negotiating which patients to accept. The situation was explained to the father by the nurse but the father clearly remained unhappy. Nurse patiently explained the situation again and told him where he could complain if he wanted to about the care on the ward in the other hospital where his daughter

is. She said to me afterwards that he was still clearly angry and not listening to her explanations, the female doctor sitting next to her said " he was like that yesterday with me too" and between them they dismissed him with a shrug. (observation notes 15)

In this situation the father was seeking to protect his child from what he perceived as inadequate care elsewhere, protection being a central aspect of the father role (Lamb, 2010). The nurse who spoke to him was a junior staff nurse who, within the culture of the ward, had very little influence over the senior nurse and consultant and whilst she was polite and patient when she spoke to him, used the term "angry dad" to dismiss his concerns after the phone conversation, an action which received corroboration from the junior doctor.

The scenario above could be seen as an example of rationalisation, as described by Collier (1994), where the reasons sincerely given for actions by an agent are not the real reasons for that action. In labelling him as an "angry dad", the nurse was able to justify her decision not to refer the father to either the senior nurse or consultant, who did have the power to respond to his concerns. Thus she would not be acting beyond the scope of her position in the ward hierarchy which was in fact acting as a generative mechanism.

Waiting was a source of anger and frustration for parents yet waiting was a constant feature of my observations. Children referred to the hospital via their general practitioners would be assessed on a separate assessment unit between 1000 and 2000 on weekdays. At weekends and outside of these times children were assessed on the ward. On arrival, they reported to the nurses' station and were asked to wait in a corridor until a nurse was available. Frequently this involved a long wait, sometimes of 2-3 hours. During this time the children's (and therefore the parents') status was ambiguous. As the children had not been assessed, no decision had been made as to whether they would be admitted; therefore nurses did not perceive the children as patients.

Often, the children and parents waiting in the corridor appeared to be invisible until a member of staff was available; parents would sit patiently whilst staff walked past as if they were not there, avoiding eye contact. The corridor appeared

to be a liminal space in which parents and children awaited admission, being apart from their normal family life yet not yet part of the social world of the ward, reflecting the concept of liminality developed by Victor Turner (described by his wife in Turner, 2008). The medical decision that the child should stay on the ward and the nursing assessment/interview and documentation that ensued, was thus a ritual that granted the status of patient to the child. That is, it was an admission in both the nursing sense of the word and in the sense of being allowed in, which led to the child and their parents becoming part of the social world of the ward.

The other waiting identified by fathers as stressful was that of waiting for test results.

"So it was a horrible night and it was just the waiting was the hard part really. Waiting for the test results" (Frank and Tara, couple interview).

Parents also waited for their child to be seen on ward rounds, for clinical aspects of care to be done- such as intravenous drugs to be given, and for everything to be ready for the child to go home. Fathers and nurses recognised that such waits could be emotionally taxing as parents experienced their relative powerlessness and lack of control over the hospital's administrative processes.

"And then with the fathers one I've had a few times and he gets frustrated because he wants things to be done on time and the medicine should be up so they can go home as soon as the doctors have said they can go home rather than waiting " (Una, nurse interview)

4.3.3 The need for reassurance

In interviews fathers frequently expressed a need for reassurance from nurses, particularly in the early hours after admission of the child.

"cos I just kept asking them.. or if something happened I'd go and get them and stuff" (Frank and Tara interview)

*"And at the first level of course we all need the same thing which is to be reassured that our son or our daughter is fine "(*Greg, father interview)

"A: So you know, you felt that these girls see babies all the time. They know that he's looking better. I suppose a nurse wouldn't say "God he's looking better" if he wasn't really (laughs). So you do need that reassurance as true as it is or not. If someone tells you something enough times, true or not, you start to believe it. So it's kind of what you need

I: it 's what you needed?

A: And that's what we got" (Adam, father interview)

Whilst fathers identified the need for reassurance and some received it, there were suggestions that it was not always forthcoming.

*"You know I.. feel .. I could have done with a bit of reassurance" (*Greg, father interview)

"She got better very quickly which I suspect the hospital were expecting but you know we just didn't .. On the Tuesday especially, Tuesday morning she'd lost a huge amount of weight and Thursday evening we were taking her home so.. it was a remarkable turnaround and I know people had been saying it would happen quite quickly but you know I didn't, it would have been quite nice to have had a bit more you know um .. been given the confidence that that could happen, which we didn't so you know Tuesday was quite a difficult day so if I'd known that they do genuinely recover that quickly then it would have been, well it might have been different," (Greg, father interview)

Fathers in this study did not express guilt about not being able to prevent or protect their child from illness or injury; yet such feelings of guilt have been identified in earlier work with parents (Melnyk, 2000). It may be that guilt is a *maternal* rather than *parental* response to acute childhood illness or injury, yet this has been obscured by researchers' tendency to use the collective term "parents".

4.3.4 Painful procedures

One aspect of the early period after admission which fathers described as "hard" or "tough" was their child undergoing painful procedures such as blood tests, and in particular lumbar punctures. The evidence of the effects of presence during painful procedures on parents is ambiguous. This experience was identified as the source of most stress in a study of fathers of children in intensive care and a general children's ward in a study by Board (2004). Yet Piira *et. al.* (2005) found from a systemic review of quantitative research, that there were no reports of greater overall stress among parents who had been present during painful procedures than those who had not. Swallow *et. al.* (2011) found that fathers took responsibility for holding their child during repeated painful procedures as part of their protective role.

On the wards in my study, painful procedures were usually performed on children in a separate treatment room. Staff usually assumed a parent would be present during venepuncture, though they expected to be in control of who was and was not present and usually limited this to one parent.

Chris, whose daughter aged ten, had emergency orthopaedic surgery, explained how he had tried to prepare her but also showed the impact that her intravenous cannulation had on him. Up until this point, he had been an assured and fluent interviewee. This point was the first time he hesitated and looked away.

"well on the way in we'd talked about that she was going to go to sleep and the one thing she was afraid about was needles and having to have an injection. And I knew that they were going to have to put in a catheter and so trying to explain that...

...She didn't like the inevitable injection, the discomfort of having the catheter fitted. That was probably the hardest part because she became quite tearful at that point, she saw the ..' I'd rather be at home'..um.(long pause)." (Chris, father interview)

All parents were strongly discouraged from being present during lumbar punctures. Lumbar punctures seemed to have particular significance for both staff and parents, being perceived by both groups as risky, delicate and an indicator of the severity of the child's illness. The staff justified the exclusion of parents from lumbar punctures on the grounds that performing them was unpleasant to see and children become distressed whilst it is done, therefore parents would become too distressed if they witnessed it.

"Yeah um er the lumbar puncture when the doctor saw the stress she was under, they asked us both not to stay in the room. If that was ok, my wife refused (laughs). Eventually you know we decided that was sensible because you know, what the doctors advised us what a lumbar puncture involves and how our daughter might react to it, that it involves a lot of screams. It's a very delicate situation and they want to wholly concentrate on getting it perfectly done the first time, the lumbar puncture, so .. Fortunately everything worked out so it was a good release. Yeah we were both waiting outside and I was there with my missus and I think she was in her own zone to be honest (laughs) to be totally honest so .. I mean I was distressed" (Harry, father interview)

"During a conversation with a mother she says 'he's having a lumbar puncture and I'm sort of glad I'm not going to be there. I've been in tears a lot and everything. They've told us we can't be there'." (observation notes 35)

These decisions about parental presence during painful procedures were made by doctors and supported by nurses; they reflected staff concerns rather than the wishes of parents or needs of the child. Such decisions could be seen as frustrating the protecting role. This demonstrates a disregard for the original reasons for parental presence in hospital- the reassurance to the child in a stressful situation from the physical presence of an attachment figure. However staff sought to

persuade rather than enforce parents' absence. If fathers persisted in wanting to be with the child, they were allowed to be, thus showing that fathers' agency could influence both their own and their child's hospital experience. One father described how he resisted efforts to persuade him to leave.

"it wasn't nice watching him going through all the tests because some of them, like the lumbar puncture was quite.. quite.. ... tough on a little baby so..

I: So you stayed while he had that done?

F: Oh yeah yes I stayed with him through all the tests..

I: Were you asked whether you wanted to stay or did they presume that you would?

F: Yes, yes, they warned me, they said "most parents want to go out at this point" which made more determined to stay .. (laughs) (Frank and Tara couple interview)

I observed on several occasions a father arrive on the ward when their child was undergoing a painful procedure such as venepuncture with the mother present. In these circumstances, the father would not, for example, be offered the chance to swap places with the mother. The following extracts provide a typical example:

"Father arrived with 3 children; mother is with 1 yr old in treatment room being seen by doctor. Nurse quickly came to speak to father- told him baby was being seen, taken to playroom with the children, not given the option of going into the treatment room" (Observation notes 18)

"Child having bloods done in treatment room- screaming ++, father and sibs are in the playroom and must be able to hear the screaming." (Observation notes 18)

And a moment later

"a nurse is talking to the child's father in the playroom- the child who was screaming having bloods done – he is with the sibs, she is giving him instruction and is speaking loudly and slowly- sounds patronising to me – she says 'it is very important', then when she'd finished said 'by the way the bloods are finished now'" (Observation notes 18)

Thus, nurses are knowingly or unknowingly managing fathers' agency.

On other occasions, parents were given an active part in holding their child when unpleasant procedures were performed.

"she was given a number of tests.. .. er heel pricks.. one was a urine test.. they checked her stool.. we had to.. have .. a tube put down her nose into her stomach to .. feed her so .. er .. I had to hold her .. down while she had that put down- she didn't like that one bit as you can imagine ..so .. and she was on a drip." (Greg, father interview)

I asked Greg to expand on this experience,

"... It was awful, yeah, didn't like that, didn't like that and obviously she's kicking and screaming, getting very upset and I just wanted to pick her up and hold her ,which obviously I did afterwards so ..." (Greg, father interview).

So Greg found his involvement distressing yet was not given the option of opting out, in contrast to parents' exclusion from lumbar punctures in order to protect them from seeing their child distressed. He also demonstrates the importance of physical contact between him and his child, showing again the importance of the embodied father-child relationship.

In seeking to explain this inconsistency further focused observation revealed that if nurses undertook procedures, nurses used parents as assistants, for example to hold the child still and assumed that they were happy to do so. When doctors performed procedures, nurses acted as assistants so parents were not needed to hold the child still. Nurses showed little acknowledgement of the impact this level of involvement might have on parents.

"I: Okay, and do you think again that the nurses knew how you felt?

G: Er.. well it's not something that I've ever really thought about but no I don't think they did, I don't think they did. .. Um.. It's not that they saw me just as somebody else helping out, clearly I was more than somebody helping out but in terms of what that might mean to my emotional well-being I don't think that was an issue that came up, no at the time there's something much more important going on" (Greg, father interview)

So whilst in the literature, parental presence during painful procedures is discussed in terms of the benefits to the child, my observations suggest it is as much to do with staff convenience and their confidence in performing a procedure under parental scrutiny.

4.4 COPING

Fathers adopted a number of emotion – focused, appraisal focused and problem - focused strategies to cope with the stress of their child's illness.

4.4.1 Emotion -focused strategies

Emotion-focused strategies are often described as being more commonly used by women than men (Katz, 2002; Clarke *et. al.,* 2009), yet in this study, they were used by some fathers in the early hours or days after the child's admission, when there

was uncertainty about the child's condition. Fathers did not identify talking to nurses about their feelings, suggesting that nurses were too busy to talk to and that they had little insight into how fathers felt, although some felt that nurses did spend some time with mothers providing emotional support and that mothers needed this.

"I don't know that they were really appreciative of how it was, I don't think they ever sort of asked how I was so ... it's just that there was no "Look I know this is going to be really tough for you" (Greg, father interview)

"really just some support for Lorna would have been good . I mean particularly when I wasn't there it would have been good if she'd had some support" (Yannis, father interview)

Talking to other parents- particularly fathers was seen as supportive, although their opportunities for doing so were frequently limited by their child's location on the wards. The absence of a communal space for parents meant that fathers of children who were in cubicles had very limited opportunity for interaction with other parents, whereas this was easier for fathers of children in the open bays.

"There were a couple of people there that you did get to know sort of a little bit more um but everyone on the ward in there is in the same, a similar position- their kid's in hospital so you're talking more among the parents of other patients rather than with the nurses." (Jake, father interview)

During a conversation with a father of a child who had experienced repeated admissions to several hospitals:

" He talked about how helpful parents of different children can be to one another and to see other families in the same position as you" (observation notes 39).

One father described actively seeking people outside the hospital with whom he could discuss his situation, suggesting that this might be unusual behaviour for men.

"I'm possibly slightly different cos I'm quite .. aware of the psychology and the.. needs that you need for good mental health so I knew that I did need to go out and you know just let it out. No-one can actually help but you just need to...." (Ivor, father interview)

Some interviewed fathers stressed the importance of "being strong" for other family members. This has been identified in other studies in relation to children in intensive care (Colville *et. al.,* 2009), childhood cancer (Chesler and Parry, 2001)

and chronic illness (McNeill, 2004). This clearly relates to the protective element of the father role.

"and also if I.. am falling apart, who's there to support the rest of the family? In my absence –if I'm not there to support them, who is? So I look at it like that, that I need to be seen as a role model to them, that if I can cope then hopefully they can cope as well "(Harry, father interview)

"nevertheless it's a frightening and alien environment for her and I wanted her to be as comfortable as possible so if she saw me comfortable with it, she'd take comfort from that" (Chris, father interview)

"Yeah, you're absorbing everything when you're in the hospital and putting on a brave front but there's only so much a sponge can take and then you need to let it out somewhere else" (Ivor, father interview).

Taking time out was identified by some as a coping mechanism, although fathers experienced a conflict between their need to take a break from the ward and their need to be with their child. Some were reluctant to leave the ward because of anxiety about gaining access again via the doorbell (see discussion in Chapter 6).

"but I didn't know if I went home whether I could get back in" (Ivor, father interview)

Since only breast-feeding mothers were provided with food by the wards, anyone else was required to leave to eat, so were in effect obliged to take breaks from the wards. I observed that some chose to go without food rather than leave their child and others described rushing back as quickly as possible, so that in effect these enforced breaks became stressful.

"you know around 12 o'clock I used to do go down for a sandwich, and he's such a boy that he wouldn't leave me for more than two or three minutes, so yeah there was one nurse (name) she was our nurse, so I asked her then if she can look after him just while I'm going to get a sandwich and I came back and he was [very quietly] crying for his daddy" (Barry, father interview)

Nurses encouraged, supported and enabled parents whom they perceived as stressed to leave the ward for short periods of time, but not those who they considered to be coping, as the following contrasting extracts reveal:

"A comment from a nurse during handover: 'mum's quite sensible but at the end of her tether so that's why I've sent her off' " (Observation notes 39)

"But it would have been nice if someone had said "Why don't you go out and give your wife a call. I'll look after Lucy for a moment", or even "look she's asleep; you can get away for two minutes." (Greg, father interview)

In the first extract, the nurse, by her use of the phrase "I've sent her off" suggests she sees herself as having some authority over the mother, and in the second, Greg

suggests that parents may in fact need some direction from nurses to look after their own needs.

Distancing, distraction and denial have been identified as fathers' coping strategies in studies of fathers of chronically ill children (Peck and Lillibridge, 2005; Waite and Madill, 2008), yet I did not find evidence of either. This may be because they are adopted as coping strategies in response to longer-term stress or this may be a result of the recruitment strategy in this study which included only those fathers present on the wards, so fathers who distanced themselves from the situation were not in the study.

4.4.2 Appraisal focused strategies

Some fathers experienced helplessness, and coped by surrendering to events:

"Then all of a sudden all the responsibility's taken away from us and we don't know, don't really know what's going on, we're just there for the ride".(Adam, father interview)

"So it was a bit of a whirlwind day to get there.. and then, when we got onto the ward, it was, it just felt a little bit... lost" (Ivor, father interview)

"you just lose days because you don't really have time to do anything properly because you're rushing to get back to the hospital" (Ivor, father interview)

"I think the majority of time I was just functioning on autopilot" (Derek, father interview)

Others coped by trusting the staff:

"It was sort of- she'd saved him. Yeah you got that instant respect for people and just because it was her that was there it didn't matter. It could have been any of them so you just feel like you're in a really .. safe place." (Adam, father interview)

"But at the same time we knew that she was in the right place" (Greg, father interview)

"it's their job, they know what's going on.. I mean they make their recommendations, they do it for a reason so you trust what they're saying" (Jake, father interview)

*"it was trying to er listen to what the doctors nurses and various people say" (*Greg, father interview)

Some fathers described actively managing their own and others' (principally their partners) emotions and thoughts:

"and try to keep my wife relaxed, well as relaxed as she could be and trying to keep myself calm, and trying to keep optimistic that things would work out .. ... okay" (Greg, father interview)

"So it was kind of... taking it day by day, passing the time as well as we could really, getting more and more confident with him and the situation was getting better" (Adam, father interview)

Kristensson-Halstrom found, in her study of parents' strategies for feeling secure, that fathers identified trusting professionals more frequently than mothers (Kristensson-Halstrom, 1999), so this may be a gender-sensitive coping mechanism.

Rationalisation was also evident:

"As long as my child's happy you know as long as my child is okay at the end of the day I don't care how – all means justify the end as long as the end is satisfactory so that's all I care about to be honest" (Harry, father interview)

"what makes me comfortable and positive during an experience like that is purely how Mathew [his child] is feeling[...] if he is being put at ease then that makes me happy" (Zack, father interview)

4.4.3 Problem-focused strategies

Seeking information and taking control have been identified as responses to the stress of being the parent of a severely ill child, typically adopted by fathers (Colville *et. al.,* 2009). Both were evident in this study.

Seeking information and understanding emerged from interviews with fathers and nurses and from observations. Fathers sought information from members of staff, particularly doctors, other parents and external sources- predominantly the internet. Fathers associated information with power, in a situation in which they were relatively powerless.

"using the internet basically as a resource, reassured me immensely so I suppose that's something that I'd say, you know they say knowledge is power so, as long s it's positive information... If I feel in understand what it is going on then and I er.. er.. understand.. the ramifications of the different options that I've got.. um that makes me feel more in control and more comfortable..." (Zack, father interview)

"I'm one of these people who if something's got to happen, yeah I know it's got to happen ,but tell me why you're doing it, don't just do it , don't expect me to know. I want to know why it's happening and why you've got to do that to my son. I mean you're going to cause him a considerable a lot of pain. If I know why you're doing it then I can make it better but if you don't tell me why.." (Derek, father interview)

"you have some fathers who come up and say" Right what's going on, I want to speak to the doctors" So you get some that are quite assertive like that.." (Zoe, nurse interview).

"1330 father approached desk to ask when he could speak to doctors as he had missed the ward round, told when doctors would be back on the unit" (observation notes 2)

During my conversation with the father of the child who had experienced several admissions, he showed an understanding that whilst not all information would be

positive, it was still important to know because it enabled a parent to prepare, therefore contributing to coping:

"he talked about the importance of being prepared to ask the difficult questions – "the ones you might not want to hear the answers to –such as survival rates and success rates" – "so that you know what you're dealing with" (Observation notes 39).

Given that this study is focused on unplanned admissions, the children were often initially undiagnosed, therefore there was limited opportunity for fathers to seek information from sources outside the hospital or to take control. However one father, whose daughter needed emergency orthopaedic surgery, which the family had experienced before, clearly demonstrated how he took control of the situation from the initial journey to hospital to through to discharge. In doing so he used his knowledge of the processes the child would go through and his personal knowledge of his child. He described how *he,* rather than the nurses, had suggested using a pain assessment tool, and also how he tried to ensure that operating staff responded to his daughter as an individual.

"it was important to me and it was important to Tasha [child- patient] as well because I wanted the staff to get on with her, to see her as a little girl, not a patient, ***not just a patient****"* (Chris, father interview) (his emphasis)

Whilst Chris was successful in obtaining some control over his child's care, this was the exception. Chris was confident, polite, articulate, with an air of natural authority and gently assertive. In interview he described how he takes on the role of managing interactions with healthcare for members of his family, including his mother in law, because in his words:

"my wife is far less comfortable around, and she knows it, around hospital and the medical profession and um I respect them but I'm not intimidated by their knowledge. If I don't understand something I have no problem asking. I don't mind looking a bit of an idiot so in those kind of situations it tends to be me that gets involved" (Chris, father interview).

There were risks however for fathers who did not have Chris's interpersonal skills who sought to exercise power (see section 4.5.6).

4.5 FATHERS' AGENCY

In this section, evidence of the range of fathers' agency is discussed, and this clearly relates to one of my research questions: what do fathers do when their child is in hospital? This also relates to father involvement, conceptualised by Pleck (2010) as comprising of: positive engagement activity, warmth and responsiveness and control.

Fathers' actions encompassed childcare activities, putting self last, providing, protecting, monitoring and expressing care.

4.5.1 Childcare activities

I observed fathers undertaking the same range of childcare activities as mothers, such as feeding, washing, entertaining, comforting. I did not undertake a quantitative comparison, either by frequency or amount of time spent, between fathers' and mothers' childcare as I was not concerned with the differences between fathers and mothers in my study. Such a study was undertaken in Canada by Tourigny *et. al.* (2004) who found that fathers and mothers undertook the same types of care activities with their post-operative children, but that the frequency and amount of time spent by fathers was less than by mothers. In my study, fathers were observed carrying out these activities when mothers were present on the ward, in addition to when the father was the sole family member present, suggesting that these activities were part of their normal role in family life rather than that they undertook these activities only when mothers were unavailable or unable to do so.

"Sibling is sitting in cot with baby, father changing baby's nappy, mother sitting watching father, involving the sib in baby's care." (observation notes 28)

"Father is changing baby's nappy, mother is around but not immediately present. Baby is receiving oxygen via nasal prongs" (observation notes 38).

Fathers were thus observed to undertake aspects of childcare independently and autonomously. These caring activities extended to assisting with medical or nursing interventions.

"nurse is giving iv drugs. Child is sitting on mother's lap and the father is holding the child still to help" (observation notes 27)

"father is holding a child still while nurse records oxygen saturation, child uncooperative , father tells child and tries to help, persuading child to cooperate, child refuses. Father is encouraging the child, tells the child off for kicking out. A few minutes later, the nurse has left, the father is giving medicines and the child is cooperating" (observation notes 32).

Yet nurses were keen to state that whilst "good" fathers did perform childcare, not all fathers did.

"You get dads who want 100% completely involved, who know everything and almost take a lead, and then you get the dads who come in for an hour, sit there while mum has a shower, then they go off and get the paper and then they come back and have a cup of coffee and then they tend to disappear again" (Wilma nurse interview).

Whilst in interview nurses stated that it was fine if fathers (or mothers) did not want to undertake childcare activities, there was clear group disapproval of those who did not, for example, this comment made during handover about a father who did not:

" there's loads of kids at home –that's why he came in and fell asleep" (all staff laugh) (observation notes 31)

4.5.2 Putting self last

Putting self last is a recognised phenomenon among fathers of children with chronic illnesses and it was clear that fathers in this study saw their own needs as secondary to the child's and the mother's.

Many of the fathers described how they put their own needs last in order to ensure that the needs of the sick child, the mother and other children in the family were met.

*"so it was quite difficult to make the decision I'm just going to leave them there and .. look after myself, when I didn't have anything wrong "(*Ivor father interview) .

"I don't think about my personal needs too much because they [his family's needs] *over-ride my needs.."* (Harry, father interview)

" you know, it was a real tough week, the beds in there are awful, but there's nothing you can do about that and you know, apart from the lack of sleep" (Frank, Frank and Tara couple interview)

4.5.3 Providing

Breadwinning, meaning providing has long been regarded as a central paternal role. In this study, fathers frequently described a range of providing behaviours, though

not in those terms and I frequently observed fathers bringing in essential supplies, be that clothes, food et cetera for resident mothers and children.

"A mixture of just running little errands for Sally, so making sure she had everything that she needed... and going into (town) to buy some things sometimes" (Ivor, father interview)

"So I was running about (laughs), getting all the clothes and everything because it was very late at night by the time she was admitted so it left me to run backwards and forwards with supplies and this and that". (Jake, father interview)

Fathers often spoke of meeting multiple others' needs:

*"I mean I had the oldest one going to school as well, so I was doing my fatherly duties at home as well as at the hospital (....) my wife took the duties of care for the child directly, I was there as a support to all the wife's needs, at all times day and night" (*Harry, father interview)

The providing role also includes undertaking paid work and this was an important aspect for some fathers who continued to work whilst their child was in hospital, juggling their working and caring responsibilities. There is further discussion of work as part of the provider role and the influences it had on fathers' experiences in chapter eight.

Thus, even fathers who were not present for long periods on the wards were significant agents in the child's, mother's and siblings' experiences, although this type of involvement was not acknowledged by nurses. Nurses acknowledge and valued only the contributions of fathers who "did their share" of care on the ward.

4.5.4 Protecting

There were many examples of fathers acting in protective ways towards both their children and the mothers.

"I didn't want anybody else to do it ..um, because .. you know.. my daughter so, Sarah wasn't here because you know the time, it was in an evening and .. I just.. I felt.. well this is my daughter and I want to make sure I was doing what I can.. I felt responsibility to make sure that if we're going to do anything not very nice to her I'm at least there so that she can see me. She may not be reassured by seeing me but at least I'm there, I'm not letting something happen where I've got no.. part of it. I didn't want any.. it's an invasive procedure .. so I didn't want that to be happening without me there" (Greg, father interview)

"at the nurses' station, there's a conversation between the nurses about a father who is perceived to be demanding, complaining about not having food for his child when he wanted it, not having the bed made, other things not being ready" (observation notes 19).

No nurses expressed understanding of such behaviour as being part of the paternal protective role or an understandable response to feeling unable to help their child.

This nurse behaviour accords with Coyne's finding (2007) that nurses actively managed parental behaviour through rewards and sanctions.

4.5.5 Expressing care

Providing and protecting are both behavioural expressions of care. Throughout the interviews, fathers verbally expressed care for the sick child, the child's mother and siblings.

"my wife took the care of the child directly. I was there to support my wife's needs[...]and Nadia [older sibling] was desperately, desperately missing her mum and her little sister, so you have to factor that in as well" (Harry, father interview)

"I was trying to think how I felt and clearly I was aware that I was very sensitised at that point, when she was in the pre-op room" (Chris, father interview)

"I mean worried about the baby, but also worried about Sally, trying to sort her out ..um.. she was becoming increasingly, not irrational but you know.. panicked, not making.. not knowing which way to turn" (Ivor, father interview)

"So Saturday night I then took Daphne [sibling] *home.. after he'd* [his son-the patient] *been settled[...] she was in a complete state, back to her tears and floods and everything else so I took her home to get her settled [...] I went back Sunday morning and took Daphne into town to get her some lunch and get her away from the environment* (Derek, Derek and Maria, couple interview)

Chris, Ivor and Derek described how caring had prompted them to take action and this was a typical response by fathers. Care as action has been identified elsewhere as a paternal response to childhood leukaemia - fathers fix things (Hill *et. al.,* 2009). Derek and Harry show how fathers with other children were affected by the emotional states of family members.

Ivor felt he had to challenge staff when he felt that their responses to his wife and son's needs up to that time had not been good enough.

"when I came back in on Saturday and ... ...it was just a shame that I had to sort of ***demand*** *that we got something rather than it being a bit more proactive"* (Ivor, father interview)

The quotation from Ivor demonstrates fathers taking action to try to get things done as an expression of care. I felt during the interview that such assertive behaviour did not come naturally to Ivor. Such actions included challenging staff- to provide what fathers felt was lacking or to make decisions. The risk for fathers behaving in this way was that they would become labelled as "demanding" or "angry" which as I have shown could be used by nurses as justification for taking no action.

4.6 SUMMARY

Within Houston's (2010) model of the social world, the domain of the personal encompasses the physical, psychological and social. My findings in this domain demonstrate all of these. Fathers spoke of the need for closeness and touch, the effects of invasive procedures on the child on fathers and the conception of their child as their 'flesh and blood'; they carried out physical childcare activities and touched, hugged and carried their children. The study also demonstrates embodied aspects of fathers' experience on the ward - being tired, lacking sleep and needing to eat.

My findings in relation to Houston's personal domain (Houston, 2010) regarding fathers of acutely ill children in hospital can be related to Pleck's re-conceptualisation of father involvement in their children's daily lives. Fathers determine their own behaviour within these three elements of involvement, although the decisions they make are influenced by their personal experience and the significance to them of their own identity as fathers. There are also external factors which influence fathers including social norms, history, family relationships and cultural factors, explored in subsequent chapters.

CHAPTER 5 The domain of situated activity- partnerships on children's wards

5.1 INTRODUCTION

The domain of situated activity is concerned with social encounters, face to face interactions between individuals where they assume roles, attribute meanings and respond to others (Houston, 2010). In this domain, much happens beneath the surface of the encounter, such as emotion work, self-regulation and the exercise of power (Layder, 2006). Nursing is predicated on such encounters. Individuals are continuously taking part in interactions influenced by their own expectations and assumptions of how others behave and expect them to behave, consciously and unconsciously adopting roles, making meaning and forming judgements, responding to others according to their expectations and judgements.

I found that within the domain of situated activity, three interwoven categories of interaction were evident: mother-father relationships, father-nurse relationships and nurses and parents as co-workers.

5.2 MOTHER-FATHER PARTNERSHIPS

Although fathers' contribution to the care of their acutely ill hospitalised children has been overlooked by practitioners and researchers in the past, within this study I gained a sense of complementarity between fathers and mothers, that they shared the caring for the ill child and other members of the family and supported one another. Parents made decisions based on their usual roles within the family, their own expectations of the mother and father role and their interpretations of what others expected of them. Within this section, I discuss the ways in which parents shared the care and played to their strengths and at times exhibited a sense of "us against the system" where parents felt they had to fight to get what they felt was needed for their child.

During the course of data collection, I realised that a crucial decision parents had to make was who was resident with the child overnight. My findings on this topic are also presented in this chapter as they provide insights into the previously unexplored power dynamics operating within couples who have an acutely ill child in hospital.

5.2.1 Sharing the caring

The notion of parents working as a team is evident in Clarke's study of fathers of children with cancer (Clarke 2009). Most of the fathers interviewed spoke about how they and the child's mother had both contributed to the overall care of the ill child and wider family. In relation to the child in hospital, the notions of taking turns, doing shifts or doing their share occurred frequently in my study and referred to being the sole parent present and providing care for the child on the ward. These notions were apparent in both father and nurse interviews and were underpinned by the idea of fairness.

"I think I played such a proactive role really and we split it. We split our time up quite fairly really" (Adam, father interview)

"so we decided that I would.. basically stay at the hospital during the day and she would come and do the night shift" (Barry, father interview) .

*"I suppose because we've had children who have been in quite a long time... and they're getting tired... they do sort of negotiate their way round each and say "Well I'll stay this time and you can go home" (*Yvonne, nurse interview)

An exception was Eddie, father of a teenage son. Eddie visited in the evenings and appeared content to be a little removed from the hospital experience. His wife was resident on the ward and Eddie saw this as natural because she was a mother and, because she was a nurse, felt that she was at ease in the hospital environment and therefore should take the lead in hospital.

"E: Yeah, I think she wanted to stay. It didn't bother her to stay, I think it's just the motherhood .. My mum used to be there for me all the time even though my dad was there as well, so I didn't want to take that away from her..

I: I understand

E: So I let her – the motherhood, so she said I'll stay and take care of it all so she did." (Eddie, father interview)

Two fathers were the sole accompanying parents for children who underwent minor surgery. Both Chris and Zack explained their situation, Chris by reference to his role within the family as the person who liaises with health care staff, and Zack by reference to his and his partner's roles as co-parents, both working part-time and he happened to be the person that was available:

"I guess like I said to you, me and my girlfriend Sue, we try to split everything and we do the same things. I don't think she takes the mum role and I take the dad role" (Zack, father interview).

All the other children of interviewed fathers experienced longer stays in hospital. There is evidence that mothers see caring for a sick child as central to the mothering role (Cunningham-Burley *et. al.*, 2006). It may be that in both Zack and Chris's case, because the children required day surgery, the mothers did not perceive their children as ill and were therefore prepared to be less immediately involved.

When parents were both present on the ward, I observed that practice between couples varied. When there were other children in a family, it was common for a non-resident father to bring the siblings in to the ward to visit the ill child and remain responsible them, for example by taking them out for food or taking them to the playroom. In other families, a resident mother would take the opportunity of the father being present in hospital to spend some time with the siblings, either on or off the ward.

As discussed in chapter 4, fathers were active providers of routine childcare when mothers were present, as well as when mothers were not there.

"you kind of just a series of waking him changing the nappy, feeding, going out and getting some more formula or breast milk that had been expressed previously from the nurses' station, going to the nurses' station to get it or ask them to get it so you could feed it or whilst Sally had expressed taking it back and putting things in the steriliser" (Ivor, father interview)

"Father 1 and father 2 both involved in giving care to children with the mothers" (observation notes 17)

This demonstrates that fathers were being more than mother substitutes, which was often the role that nurses attributed to them (discussed further in section 5.3.1).

Whilst all the fathers I interviewed and many others I spoke to took an active role in their child's care, some that I spoke to on the wards, particularly younger fathers, were happy to talk informally but declined to be interviewed. These men said, for example, that they had not been on the ward enough to form an opinion or that they saw caring for the sick child as the mother's responsibility, which they were happy to leave to her.

"it's not really me – it's his mother who does everything, I'm not the one to talk to" (father who declined to be interviewed, observation notes 35).

5.2.2 Playing to their strengths

Parents described how they made decisions about who would do what based on their knowledge of one another's strengths and their different relationships with their child. Couples' views of their strengths did not always accord with nurses' assumptions. Swallow *et. al.* (2011) found that parents of children with long-term conditions negotiated roles within the couple according to who was best able to deal with the particular demands at hand. Findings from this study suggest that parents of acutely ill children may do likewise.

"I think um, whenever we have a choice, you know, I tend to be the one who takes the girls to the doctor [...] it's just the way it is because I don't have a problem. I mean she doesn't feel comfortable, but if I wasn't available of course she would do these things" (Chris, father interview)

"Martha (child) *always settles a lot easier with Sam* (mother) *and obviously being in that kind of environment, she needs to.. obviously her mum was there to comfort her a little bit more"* (Jake, father interview)

During a conversation with a father whose child had experienced numerous admissions for complex health problems:

" He asked whether fathers asked different questions to mothers as he said they did as a couple, dads ask for technical things and mums ask things he wouldn't have thought of so as a couple it worked" (Observation notes 39)

I heard a mother say to a nurse as she was leaving the ward:

"I've left his father with him for a couple of hours- he understands more than I do" (Observation notes 2)

This brief extract reveals a number of assumptions on the mother's part- that the child is never left alone, that the mother has to report her comings and goings to nurses, that the mother feels the father's solo presence with the child must be

explained, as must her view that the father understands more about the child's illness and treatment than she does. As an observer of this exchange, I felt that the mother was giving staff the permission to discuss the child's care with the father.

In "playing to their strengths", parents often made decisions along traditional gender stereotypical lines, such as Jake's view that his daughter would be more easily comforted by her mother, though this was not always the case. Nurses did not show any acknowledgement that parents might make decisions based on who they –the parents- thought was the most appropriate person for that particular aspect of the situation, rather they assumed that mothers were the experts on the child.

5.2.3 "Us against the system"

Some fathers told stories of their family's pre-admission and in-hospital experiences which could best be characterised as "us against the system". These involved efforts to get health professionals to listen, to get their child's illness recognised by primary care staff, to get the standard of care or equipment they needed on the ward or to get information, often on the part of the mother. In these stories, they used words like "fighting" and "battling", suggesting that the parents as a couple were challenging health care professionals on their child's behalf.

*"we'd see **ourselves** as partners.. almost.. not to speak for Sarah* (mother) *and I wouldn't like to say we were battling against the system but .. we were.. quite keen ..to get answers.. that didn't always seem to be forthcoming"* (Greg, father interview)

Two of the mothers who joined in the interviews with fathers were particularly vociferous on this topic. It may have been a desire to be heard and a perception that I would listen that prompted these particular women to join the interview with their respective partners.

*"if something is going wrong I want someone to be there who's well informed, who knows what's happening and to talk to so sometimes thought that the nurses must have thought well, she's very pushy and very demanding and " I **need** to see the surgeon and I'm ready for him"* (Ali, in couple interview with Barry and Ali)

"and I was trying to tell him that as well, but they wouldn't listen to me and I was saying to them I know he's still in pain I now he's having problems and they wouldn't listen to me" (Maria in couple interview with Derek and Maria)

In these cases, fathers described themselves as supporting mothers in their struggles to have their views heard. There are echoes here of Waite-Jones and Madill's finding that mothers of children with arthritis frequently asked fathers to accompany them to medical appointments with the child because they felt that fathers had greater credibility with health care professionals than mothers (Waite-Jones and Madill, 2008). This view runs counter to the prevailing view expressed by health professionals, and evident in my own study, that mothers know their children best. Yet the fathers themselves in my study did not identify that they had greater influence than mothers.

5.2.4 Deciding who stays overnight

The wards had a policy that only one parent could be resident with a child overnight. This information was clearly conveyed to parents in notices displayed around the ward and in written and verbal information given to parents. Nurses frequently unconsciously conveyed a message to parents that mothers were both welcome and expected to stay, so whilst the policy was that *a parent could stay* if they wanted, the expectation was that *a mother would stay.*

Written information in the "Children's Unit Information Folder" (prepared for families by senior nursing staff and two parents- actually mothers) which hung on a notice board, accessible to parents, emphasised that only one parent and no siblings could stay on the ward overnight because space was limited.

Generally nurses perceived the resident parent as the child's main carer and presumed that this would be the mother, unless there was a reason for this not to be the case. This was reflected in the language that nurses used when giving information to parents about the ward, once the decision to admit the child had been made.

"The parental bit needs to really be dads and mums, that sort of thing, and I think kind of offer dads more of a chance to stay instead of the mums. I think maybe we say that- well "Mum can stay " 'cos probably that's the first thing that comes out of our mouths, something like that" (Zoe, nurse interview)

Therefore parents were obliged to make a decision, often shortly after the child's admission, about who would be resident with the child, having been given the

unconscious message that this was expected to be the mother. Many couples and nurses did not perceive that a decision was involved- it *had* to be the mother who stayed – either because the mother was breast-feeding, because the mother could not imagine leaving the child, or because the mother was the main carer for the child (discussed further in Chapter 6). Among parents of young babies, breastfeeding was often given as a reason why the mother had to stay but there was also a perception that mothers had a special bond with the child that meant they *had* to be with the child. Mothers in these situations had and exercised situational power.

"I asked a father how he and the mother decided who was going to stay with the child. He replied 'it wasn't a decision, she ***had to****' "* (Observation notes 28)(emphasis original)

"So I was doing all the running around, and Sue firstly wanted to be there even more than I did but secondly felt she had to be for the breastfeeding side of it" (Adam, father interview)

"I think that cos primarily Mums are still the main carers at home they think" Oh it'll be easier if I stay"" (Zoe, nurse interview)

Often the parents of very young babies both wanted to stay overnight:

"I think with the smaller babies yeah, like the newborns, but mostly they both want to stay, not necessarily just dad. Dad wants to stay but mum wants to stay as well and that dad probably, when you explain that only one person can stay, it's normally dad that goes. Dad doesn't say "No actually I really wanted to stay", they just leave mum here.

I: And why do you think, do you have any view of why that might be?

T: Um (pause) .. don't know (long pause) no I don't know.. I think it's just one of those things that happens.. (long pause). I think well most of the time dad's at work and mum's there more anyway so I think it just happens, yep" (Tracey, nurse interview)

Frank corroborated Tracey's view.

"F: I guess the only down part ... about the hospital for me was there was no.. ..kind of ability for us both to stay..

I: Yeah

F: unless one of us wanted to sit in the chair all night so it didn't make sense for us both to stay, even if you were able to, which is a bit of a bummer on the person who has to go home. ..I think..." (Frank in Frank and Tara couple interview)

In the quote from Eddie in section 5.2.1, he uses the words "I let her stay" and "I didn't want to take that away" suggesting that he was in a position of power and authority in the situation – a traditional view of the father as head of the family-

and had acted benignly in response to the mother's need to be with the child. However, Gatrell (2007) has argued that childcare has become an arena for the exercise of power within couple relationships. It seemed to me that many women in the study, including Eddie's partner, exercised power over the decision of who should stay overnight in hospital with the child, such that men felt there was not even a decision to be made (discussed further in chapter 7). Nurses largely concurred with this. I interpreted this as being evidence of the importance of caring for a sick child to the mothering role, even among couples who might describe themselves as co- parenting.

As members of society, female nurses are influenced, consciously or otherwise, in their practice with parents by prevailing societal values and norms, and thus this understanding of mother as *the* source of care for ill children was guiding the assumptions and actions of the nurses on the ward. This demonstrates how events in the domain of situated activity are influenced by factors from the other domains of the social world.

However there were exceptions - Frank and Tara discussed how he had in Tara's words "insisted" on staying overnight with their nine week old son, even though she also wanted to do so. She spoke of how difficult it had been to be at home. Their situation was complex as Tara had an older child from a previous relationship to consider, whereas the baby was Frank's only child. I gained a clear sense though of Frank exerting power in insisting on staying that first night, although they did take turns later in the admission. Gatrell (2007) suggests that some fathers within cohabiting/ married relationships are using a "Fathers' Rights" agenda, familiar from campaigns relating to fathers' claims for contact with their children post-divorce, to challenge the maternal sphere of influence.

On occasion, exceptions were made to the "one parent can stay" policy, which appeared to be at the discretion of the nurse in charge at the time of admission.

"There's a partner of a mother who has stayed too – not just the one parent as per the policy- doesn't seem to be an issue for anyone today." (observation notes 16)

"I was asleep on the camp-bed next to the cot and Sue was on the chair and she was half awake and at one point she looked over at him but this was about 3 in the morning " (Adam father interview)

A father I spoke to explained that he stayed with his son because the boy was "a daddy's boy", suggesting that children's preference could influence parents, which accords with the findings of Wolff *et. al.* (2011) that some chronically ill children preferred their father to accompany them on hospital visits.

I also observed that fathers were more likely to be resident with children under one year than any other age group. Roberts-Homes (2009) suggests the greatest increase in fathers' involvement in parenting activities has been seen among the parents of pre-school children, which supports my observation. A further explanation could be that babies under one were almost always nursed in single cubicles whereas older children were more likely to be on the open ward. Fathers may have felt more at ease in a single cubicle than in an open bay, where they would be sleeping next to their child, but in the same space as three other resident parents who were likely to be mothers. Thus a number of factors combine to decrease the likelihood of a father being resident on the ward overnight.

In this section I have shown the complexities and subtleties of how parents worked together as a team to meet the needs of the ill child and other family members. Whilst Swallow *et. al.* (2011) have shown this in relation to families of chronically ill children, this has not been identified in the acute setting in the many previous studies into family centred care. This would seem to be because researchers have focused on the experiences of the person, usually the mother, who was resident with the child, rather than considering the family as a unit.

5.3 FATHER NURSE RELATIONSHIPS

Generally, fathers and nurses spoke in positive terms about one another reflecting overall what I observed on the wards. The length of the child's stay and the child being a frequent attender were associated with more friendly relationships. As with other general children's wards, lengths of stay were often short, twenty-four- to forty eight hours, although it did seem to me that that there was a tendency for children to stay longer than on other similar units with which I am familiar.

However, there was a rapid turnover of patients which meant that nurses often did not care for a child and family for more than one shift.

"Only 4 patients the same as yesterday – this does not give nurses long to establish trusting relationships and negotiate care" (Observation notes 4)

This situation was exacerbated by nurses' shift patterns. Across the week, a full time nurse worked three thirteen and a half hour shifts which were unlikely to be on consecutive days.

5.3.1 Nurses on fathers

Despite using the term parents and arguing that they treated all parents the same regardless of gender, nurses did identify that their relationships with fathers were different from their relationships with mothers. The nurses I interviewed ranged in age from twenty three to fifty five and in experience as a qualified children's nurse from three months to thirty years. All reported having received no formal education or training at all on working with fathers as these extracts from interviews with Zoe and Yvonne (from either end of the age and experience range) demonstrate:

"I: so the first question, could you tell me do you ever remember having any specific education or, training, for working with fathers specifically?

Y: No, not that I can recall, no. Just generally parents, but I don't think we had any specific training for working with parents either. We just... it's skills that you pick up as you go along, doing the job" (Yvonne, nurse interview).

*"Z: Not with dads not specifically, training with regards to working with parents in partnership but not specifically dads, no." (*Zoe, nurse interview).

Zoe did however think it had been mentioned during her recent pre- registration training that:

"I remember they [fathers] *were mentioned as having more heightened stress levels when their child was in hospital so I do remember that being mentioned but apart from that not really anything else..."* (Zoe, nurse interview).

Some nurses expressed the view that fathers may be seen as not knowing much about their children:

*"just that I think that fathers are often viewed as not knowing very much about children and I think that's... probably a wee bit old fashioned but um it's still true even within my – my brother in law he's an old-fashioned.." (*Sam, nurse interview).

Whilst Sam was an exception in verbalising this, nurses' behaviour frequently suggested that this was their view.

In general nurses (and other staff) appeared to regard fathers as substitutes for mothers rather than recognising either the inherent value of the father-child relationship or that fathering may be different to mothering. For example, if a father was resident overnight, this would frequently be explained in handover in terms of the reasons for the mother's absence such as her illness or having other children to look after. No such explanations for a father's absence were offered if a mother stayed. This provides further evidence that nurses had "resident mother" as their default expectation. However, if there was a reason that a mother could, or in the nurses views, should not stay overnight, the father was expected to stay and be an active carer for his child

"there's a discussion between nurses at handover about a mother who is seven months pregnant who has had to stay overnight because the father said he was unable to look after the child –the clear implication was that the nurses thought he should have stayed so that the pregnant mother could go home" (observation notes 12)

Nurses saw fathers in the role of mother's assistant, sometimes less competent and lacking in decision-making authority. Some nurses felt that some fathers needed to be told what to do in relation to routine childcare activities, whereas mothers did not.

"But sometimes if it's just dad who's around they sort of know what to do but when you speak to them they're sort of "But I have to check first". So then like they have to get permission from the mum, it's that they can't... I suppose it's about making choices really isn't it whether what they decide is the right choice...

I: Okay so you find that fathers will check with mum who's not here

T: Yep..

I: whereas mums will just do things on their own?

T: yeah, exactly yeah, yeah" (Tracey, nurse interview)

"and it's all a new experience for them staying, then tending to get organised is not something they're used to but we expect them to do their part as well. I think they have an expectation that the nurses will do things.." (Val, nurse interview)

Whilst maternal competence in routine childcare was assumed, paternal competence had to be demonstrated, as Adam seemed to recognise.

"But I think that perhaps because I spent so much time there that I got to know them they realised that I was quite a.. I guess a fairly capable dad, rather than a stand back and watch dad which I think maybe blurred the lines of mums and dads." (Adam, father interview)

Some mothers also demonstrated the attitude that fathers had to prove themselves in order to be trusted with the child and nurses seemed to endorse it.

Nurses interpreted some fathers' hesitancy to carry out routine childcare as lack of competence or lack of will to do so. However an alternative explanation might be that fathers who experienced maternal gatekeeping in childcare in their normal family life may have been placing nurses in the gatekeeping role. Alternatively, fathers as men, may have been less familiar with role expectations in female dominated care and education environments and were therefore less aware and responsive to the nurses' attempts that Coyne (2007) identified to socialise parents to ward norms.

There were resonances in nurses' views of the findings from a discourse analysis of the portrayal of fathers in childcare manuals and magazines by Sunderland (2000). She found that in this literature aimed at parents (i.e. mothers); fathers were portrayed as bystanders, mothers' less than capable assistants, entertainers or managers (Sunderland, 2000). These roles seem to undermine the significance of fathers for young children. Such portrayals in the media may both reflect and contribute to a broader cultural perspective on fathers' childcare skills.

Nurses appeared to think that mothers coped better with the demands of caring for an ill child.

" Now I think... that dads do say "Oh I need my sleep" or if dads have been here at night and they've only got four or five hours' sleep, they let you know, they will say that to you, whereas the mums almost accept that that's part of the role."(Wilma, nurse interview)

"there are some dads who just can't deal with um their child's illness. It's like they can't get it into their head- you know what they say about men, they can't multitask and all of that." (Val, nurse interview)

Yet nurses were certain that fathers and mothers had the same needs and should be treated the same. They appeared not to perceive the contradictions inherent in seeing fathers as less capable carers who are less able to cope with the demands of

the child's illness than mothers whilst also maintaining that fathers and mothers should be treated the same.

5.3.2 Fathers on nurses

Fathers recognised and valued the nurses' professional knowledge and expertise and were appreciative of the care nurses provided for their children and for the mothers.

"we couldn't have really asked for any more from the staff from their professional side of things they're obviously all very capable at what they do and cool and calm under pressure" (Adam, father interview)

Fathers perceived nurses as technical experts who came to perform technical aspects of their child's care and left when it was complete. This was also the pattern of interaction that I observed consistently over the course of my visits.

"we was left to our own devices and they would come in and do what they had to do every hour or so and disappear again. There wasn't a lot of interaction between us and the staff" (Jake, father interview).

"but other for any particular.. medical if you like check visit um to check that that the drip was doing fine, things like that, there was no social interaction. I'm not sure that there should be but there was never any "how are you doing It's okay, it's quite difficult, why don't you come and have a cup of tea" or anything like that. I mean as I say I may not have taken it but it would have been nice to have to er have had... er the choice" (Greg, father interview).

Fathers described nurses being short of time, always busy with other patients who they perceived as more in need of care than their own child.

"Fortunately it seemed to be a fairly quiet day so, but it was a bit busy so er they've got priorities and there are worse cases and less severe cases. And we were less severe" (Chris, father interview).

"you know you don't really see them too much because there's obviously a lot of more seriously ill children there um so I don't know that they were really appreciative of how it was" (Greg, father interview)

Nurses therefore had little contact with children or parents beyond a purely functional level. Fathers, including those who had been resident overnight, described minimal contact with the nurses and suggested that there was little continuity in who looked after their child.

*"We had (laughs) lots of different nurses so there was never much of an opportunity to build up relationships" (*Greg, father interview).

Thus, fathers described friendly, supportive but fairly superficial relationships with nurses; consequently, nurses had little understanding of individual fathers'

emotional states. However, the older, more experienced nurses I interviewed showed insights into parents' experiences as a whole. Whether these insights were the results of accumulated clinical experience with families, were by virtue of their greater life experience or because the particular older nurses I interviewed were also parents themselves, or all three, it is not possible to say.

"We just... it's skills that you pick up as you go along, doing the job. You can't teach other people how to relate to parents, they and their needs. And I also think being a parent helps [yeah]. So you know what they're going through and you know how they feel about their children". (Yvonne, nurse interview)

As in similar studies (for example, Lewis *et. al.*, 2007) nurses were seen by parents to be perpetually busy. Fathers' perception that nurses always had sicker patients to attend to was often inaccurate, yet it may have inhibited fathers from engaging in anything other than instrumental conversation with the nurses when they came to perform an aspect of care, particularly given Lewis *et. al.'s* finding that parents felt guilty for consuming nurses' time (Lewis *et. al.,* 2007). This extract from Greg hints at this:

"but it did fell quite.. lonely. Having said that, all the medical staff, the nurses, were pretty good and they were chatty. You know, when they came in, I'd try and engage in conversation and have a bit of a chat and they would as well, most of them, they were fine. But it was very much ***when*** *they were there I'd talk to them rather than making an effort to come in. I'm not expecting them to do that"* (Greg, father interview).

When not busy delivering care, nurses gathered at the nurses' station around the computer, completed paperwork or chatted amongst themselves, yet parents, particularly those of children in single cubicles could feel quite isolated. Some fathers felt they might have valued the opportunity to talk. Two fathers talked to me, a female researcher who they had only briefly met once before, quite readily about how they at one stage feared their child would die, yet they did not share their fears with the nurses during their child's stay. Greg, resident overnight with his child for seven days, reported that no-one once asked how he was and Derek felt nurses regarded fathers who did not stay as "inconsequential".

Men may have been reluctant to show vulnerability by expressing their fears to female nurses who they did not know well, yet they were willing to do so with me. Given fathers' perceived need to appear strong at the time, it may have been safe

for them to disclose this to me once the child was well and at home. I wondered in interview with Greg and Ivor whether fathers might have spoken more readily to a male nurse, had there been one. Neither thought that they would necessarily. Greg suggested that a male nurse who was a father might have understood his position whilst Ivor assumed male nurses would be effeminate and therefore not someone he would have been at ease with.

Fathers judged nurses on how they related to the ill child and cared for the mother, rather than themselves.

"I'd like to see the nurse being caring towards my wife. If they're cold and calculating towards me, you know they're just doing a professional job but that's what I'd expect you know what I mean? So I'm totally different in how I view the nurse" (Harry, father interview).

"D: we had one nurse who was an absolute nightmare

M: We didn't like her, we was just praying that she was mostly on nights she

D: She would just come along and it would be like oh arm here and it was all forced and rough (she hurt him quite a few times) and you know, I've got to do it let's do it and I'm off and away, no sort of sorry mate and all this. But you'd get some of the other ones (same nurse's name) and this other nurse and I think (another nurses' name) to an extent, I mean she weren't brilliant but she would sit down and..." (Derek and Maria, couple interview)

This extract is unusual in that contains an overt criticism of nurses, although some implied criticism is evident on close reading of other father interviews. Fathers may have been reluctant to overtly criticise the nurses because I had presented myself as a children's nurse researcher or they may have been influenced by the cultural position of nurses in society. A surprising use of the word "professional" in an implied negative sense was made by two fathers. In both cases they used "professional" to mean technically competent and efficient but emotionally distant.

"I really appreciate all the help all the advice you've given [the ward nurses], all the care and attention from every one of them, ***even*** *the one my wife thought was a little bit more professional than er the others, just wanted to do the job, you know, in and out" (* Harry, father interview).

Fathers were much more ready to be openly critical of consultants, in whom this distant behaviour was expected, than nurses.

"I wouldn't say much for the consultants, you know they have many people to see and they just breeze in and out" (Frank in Frank and Tara couple interview*).*

Nurses may also have deflected some criticism by a tendency to present themselves as powerless enforcers of institutional rules or followers of doctors'

instructions. There were however a few occasions when I observed nurses "telling off" a mother for breaking one of these rules -for example for going into an area such as the dirty utility room that was designated as off limits to parents. I did not observe a nurse "telling off" any fathers.

Fathers also made judgements about nurses' capabilities, often with reference to their own working role and environment. This suggested to me that fathers were using their experience of the world of work as their reference point for understanding the social milieu of the ward. This issue is discussed further in Chapter 8.

5.3.3 Fathers in nursing records

I have suggested in this chapter so far that in interactions nurses assigned the roles of "supporter" and "mother substitute" to fathers. During the course of the study, I observed nurses spending a great deal of time completing records and I outlined the significance of the admission interview and associated records in chapter 4. Nurses made no mention of fathers in handover unless they were resident because a mother could not stay or they were perceived as a problem in some way. I therefore wanted to know whether these attitudes extended to the ways fathers were represented in nursing documentation.

When a child was admitted, nurses were required to complete a form concerning the child's social and family circumstances. This required nurses to complete the details of the child's parents, next of kin, who had parental responsibility for the child, as well as their address, GP, Health Visitor, social worker, school or nursery. As such the records provided details of the child's social context, discussed in nursing textbooks as essential information for the practice of family-centred care.

The significance of the nursing admission process and the associated documentation for the nurse –patient relationship has been widely recognised (Jones, 2009). Prior (2003) argues that documents:

"are constructed in accordance with rules, they express a structure, they are nested within a specific discourse" (Prior, 2003 pp 12-13).

The format of the ward's nursing records clearly reflected the professional discourse of partnership and negotiation with parents which is dominant within children's nursing. However the records demonstrated that parents could be involved in some pre-determined aspects of the child's care; thus just as Coyne and Cowley (2007) found, control of the boundaries of care remain with nurses so the nurse- parent relationship is not a real partnership.

Jones (2009) maintains that nurses' use of records is a social action, embedded in a larger system of activity. In the case of the study wards, the form was demonstrative of an institutional heteronormativity. The spaces on the form imposed a traditional family structure on the data that could be recorded- there was identified space for a father's name and a mother's name, but not other variants. Alternative headings such as "family structure" or "household membership" would have enabled the realities of modern family membership to be recorded. Thus heteronormative assumptions at institutional level were expressed in the records.

In practice, once completed I found these records were largely ignored. At any one time I found a proportion of these records would have just a mother's name listed under next of kin, with no explanation of why there were no details of the father, even when a male person was visiting and caring for the child. It seemed either that if a mother brought a child in on her own and replied that she was the next of kin, no further questions were asked about the father's whereabouts or that mothers were often assumed to be next of kin. Nurses explained that they did not want to stigmatise or embarrass a single mother. However this reluctance to ask about an unmentioned father enabled maternal gatekeeping- for example by omitting to mention a father who was not resident with the child. Thus, non-resident fathers could be invisible. Similarly a social father, such as mother's partner who was actively involved in the child's life would be absent from the records.

The section requiring the names of persons holding parental responsibility for the child was often not completed at all or completed incorrectly. If a man brought a

child to the ward on his own, the whereabouts of the mother was asked for and the status of his relationship with the child was established. Nurses explained that this was because there had been an incident where a male had signed a consent form for surgery, who was found later not have parental responsibility, meaning that the consent was invalid. The nurses did not appear to have considered that a female, such as a stepmother, could be in the same situation.

There was very little reference to fathers in other aspects of nursing documentation unless there was a particular problem, for example that a father was legally prevented from having access to the child.

5.4 NURSES AND FATHERS AS CO-WORKERS

Children's nurses claim to work in partnership with parents. On the wards, the Children's Unit Information Folder displayed on the wards asserted that they practised child and family centred care, although without an explanation of what that meant and:

"We work in partnership with you and your child and aim to fully involve you and where appropriate your child in the planning and delivery of care, negotiating what input you have"

"You can do as much for your child as you like. The nursing team is there to help and support you in your child's care"

Thus it is evident that, in principle, parents were expected to be actively involved in both decision making and providing care. Within this section I consider how parents and nurses operationalized these ideas, working together for the good of the child considering co-working, negotiation, parents' sense of being left to get on with it and joint decision-making.

5.4.1 Co-working

A sense of parents as subordinate co-workers was conveyed by the way in which parents reported their comings and goings to nurses.

"A mother approaches the nurses' station and discusses with nurse whether she can go home - she seemed to be asking permission" (observation notes 19)

I have already shown how fathers were active in providing routine childcare for their ill child and that both nurses and parents often assumed that this would be

the case. It was unusual to see nurses performing these routine childcare activities. When this did occur, it tended to involve children with complex needs or very young babies whose parent was not present.

"spoke to staff nurse who was feeding a small baby while mother had gone home to get things to stay overnight, she said "it's great to get the chance to do this with such a little one we don't usually." (Observation notes 35)

I did not observe any nurse performing routine childcare when a parent was present. One couple reported that a student nurse had bathed their baby, but this was because she needed to be observed practising that skill.

This demonstrates how the parental role with the child in hospital has evolved from being a reassuring presence to being a co-worker and an essential provider of care. One nurse openly discussed their position on this:

"There's an assumption that the parents are here therefore basic care will be done um, and I do think, I strongly believe that there are a lot of kids out there that are not getting the standard of hygiene that they would get at home because everyone's assuming that someone else will do it and parents, particularly if what you're saying is true, although the question's been ticked they haven't actually been asked, it's a little bit unfair for us to expect them to do the care and they're probably thinking "they'll do it when I'm not here" and of course we don't and I think that in many respects some children would be better off at home and from a basic care point of view" (Sam, nurse interview)

And spoke of how nurses could gain the broader support of parents:

"I make them all a cup of tea, my group of six or whatever I've got so that they're all in a nice friendly frame of mood for the evening. "Get them onside and they'll help you later on" is my motto. They will, they'll back off, if you're finding that you need a third hand, you can say "look can you pass me a wodge of towels" or something and get to the desk and ask them to get you a sheet and they'll do it ...." (Sam, nurse interview)

Other nurses clearly regarded parents as co-workers as the following comment during a handover demonstrates:

"mother went home last night –just when there's no staff" (Observation notes 16)

I also observed many examples of fathers and mothers assisting nurses to perform clinical aspects of care. Sometimes this involved talking to and comforting the child and at other times a greater degree of involvement such as holding the child still, or assisting with or directly administering medicines. On many occasions, if the parent had not been present, another member of staff would have been required.

"father is holding a child still while nurse records his oxygen saturations, child is uncooperative, father tells child to be still and tries to help by holding the child tighter, persuading child to cooperate, child refuses. Father is encouraging the child, tells the child off for kicking out. A few minutes later, the nurse has left, the father is giving medicines and the child is cooperating." (Observation notes 19)

"Newly qualified nurse finds dvd for 1 yr old in cubicle on their own and puts it on for him. Same nurse runs in 2 mins later – child has no one with them and has undone the bandage over cannula which is therefore at risk of being dislodged, other nurse goes in to help. This made me realise the value of the invisible labour of parents – something a parent would have just done" (Observation notes 22).

Therefore parental care was also essential labour for the smooth running of the ward.

In interviews I noticed that fathers used professional jargon such as "obs", "sats", "ivs" and "WBC". This suggested to me that they identified with the professional nursing role and were keen to demonstrate their clinical knowledge to me as a nurse.

In terms of co-working, parents were not in the same position as nurses. Whilst nurses were trained and paid carers, doing what they did every day with familiar colleagues and going home at the end of their shift, parents were in an unfamiliar place with unfamiliar people, concerned about their ill child, other family members their jobs, possibly sleep deprived and exhausted and "on duty" twenty four hours a day.

"D: they understood Maria's side of it cos the parent being there looking after the sick child but um, from my point of view as the slightly eternal wanderer kind of thing , comes in and goes back again, you know flits in and out, I didn't feel that the nurses had any idea- bearing in mind that I'm away from Maria ,trying to sort out a child at home who's at school , I've also got a day job I've got that I'm trying to do so I'm up at 6 o'clock, dealing with Phoebe (daughter) *trying to get her sorted out, explain things to her , make sure she's alright, packing her off to her friend, popping in, seeing him, seeing what's happening, coming back later and everything's changed. Then having to deal with work, back to the hospital, back to work."* (Derek in Derek and Maria couple interview).

*"It's probably different because the staff get to go home at the end of the day, but they do work incredibly long shifts, but after 12 hours they do get to go away from it whereas if you're staying with a child that's there, you don't, you're there twenty four hours day with that kind of noise, the alarms, the buzzers and the panic when something goes wrong" (*Ivor, father interview).

5.4.2 Negotiation or left to get on with it?

Negotiation and participation are central to family centred care and children's nursing practice with parents (Lee, 2007) and as such there is considerable discussion of these concepts in children's nursing literature (for a review see Corlett

and Twycross, 2006) which will therefore not be repeated here. From her research with nurses, Lee (2007) identified that nurses saw the pre-requisites of partnership between parents and nurses as being: a positive attitude, respect for child and family, good communication skills and ensuring parental understanding. None of the nurses in this study discussed partnership in such terms.

Part of the nursing documentation completed on the wards on admission provided space for the recording of the negotiations between parents and nurses regarding parental involvement in care. This requirement to document the discussion both signified the importance of negotiation and served as a tool for recording responsibility for certain aspects of care. Whilst the notices displayed said parents could do as much they wanted (but not as little!) for their child, in reality the negotiation and recording of parental involvement was confined to routine childcare, helping with specimen collection and assisting with recording fluid intake output. Whilst there was space for a parent's signature on the form to confirm agreement as to who was responsible for what, this section of the documentation was not signed by parents on any records that I saw, rather I saw comments such as "mum happy to do" written in by the nurse . Thus as Coyne (2007) found, parental participation appeared to be optional but in reality parents had no choice but to accept.

There was no scope for parents' wishes to become involved in any technical aspects of care to be recorded, nor were nurses prompted by the documentation to ask any questions relating to that. Thus the document demonstrated what was seen as acceptable parental involvement in care but also served to limit the scope of such involvement. I did not see any nurse check this part of the nursing records when caring for a patient for the first time. So whilst it appeared from the records that parental involvement in care had been negotiated, in reality it may not have been, as Sam confirms:

"nowadays it's what's on paper that matters so that as long as you've recorded that the parents want to help., you never actually look at that bit of paper ever again to see whether the parents want to help but you've got it in paper- look I've done it , it's ticked, that's all that counts when it comes to an audit...what you're not looking at is how involved do you think you were, what you're looking at is just the paperwork that they were offered the chance um" (Sam, nurse interview)

Yet nurses in interview were insistent that they negotiated the degree of parental involvement on a continuing basis.

"I: So –family centred care – tell me about how you put that into practice?

Z: I try to put it into practice by involving the parents as much as possible, so saying to them, and trying not to step on their toes. So the things that they would normally do at home like feeding and washing and hygiene needs and everything I always say like "what do you want to do?", "would you like to give him the medicine or would you like me to do it?" So you give them the choice of what they can do so that they don't feel completely pushed out. I also try to talk to them about what their concerns are and what they understand about their child's treatment, and all the plan of care things really and try to highlight things they want to ask" (Zoe, nurse interview).

"I: From an observer's perspective what would family centred care look like? What would you see someone doing that would make you think oh that's family centred care?

U: .. um talking to the parents about what they would like and how they would want to be involved in the care and giving them options for certain things" (Una, nurse interview)

Fathers seemed surprised when asked about negotiation and were adamant that no-one had negotiated with them.

"I: One of the things that nurses say they do is work in partnership with parents, they negotiate who's going to do what parts of what needs doing for the child. Do you recall anyone ever saying that, making a plan with you like –if you do the feeding and the nappies, we'll do the drugs and the

F: no

I: or did they just presume, or did you just presume that?

F: we just presumed that. Like we knew we had to have his ops done (sic) *and we knew he had to have, he had like a cannula"* (Frank in Frank and Tara couple interview)

"Z: Um ...I don't remember that many discussions about those kinds of things. I think it was more about the nitty gritty of what was going to happen and when, not in terms of the standard every day sort of care that you give to a child- like washing, dressing, blah blah, I think they kind of .. yeah they left it up to us really" (Zack, father interview).

So nurses and fathers had contradictory views. Nurses may have negotiated with mothers and presumed that what the mother had agreed stood for the father also. Val's comment offers an alternative explanation:

"It's a bit more work negotiating with them than the mum. I mean I've had experiences where you tell them and you go through the whole thing and they're still, it's just over their head and well you say ' 'you just have to get on with it- feed the child' " (Val, nurse interview)

This suggests that nurses told parents what they themselves were going to do and expected parents to know that they were expected to continue with routine child care whilst letting nurses get on with clinical aspects of care. They perceived this,

and asking if parents need help, as negotiation. The practice that I observed could best be described as "tell and leave".

"It's .. it.. was strange I suppose... they just expected you to let them get on with their job" (Jake, father interview).

"Nurse outlines plans to parents and says as she leaves" just give me a shout if you need anything" " (observation notes 29).

The phrase "left to get on with it" occurred frequently in father interviews. Yet although that was how they felt, it was nonetheless important to fathers to continue in a parental role:

" even when he was in HDU he was wired up to everything, we could lift him out of the bed and put him on our lap for feeding, give him his milk, so that was our.. our responsibility if you like, our little bit that we could do was to keep him fed. And they, everyone was very encouraging as far as that was concerned and we felt we were taking just a little bit of that responsibility back, to keep him fed and watered really and that was our bit..." (Adam, father interview)

One father, however, did feel that he was in partnership- he felt he had a clearly defined role and a particular contribution to his daughter's care.

"Yes well I didn't really think of it in those terms but it was a partnership. My job was ... ... as parent is to understand as much as I can so that I can help explain everything to my daughter who doesn't understand everything." (Chris, father interview)

As stated earlier, Chris's daughter underwent surgery for a fracture which she and he had both experienced before. Therefore the course of the admission was predictable meaning that he and she both knew what to expect and knew what options were available, unlike parents of children with unknown diagnoses on admission.

5.4.3 Joint decision-making

Partnership working with parents includes involvement in decision-making as well as care delivery. Swallow *et.al.* (2011) found both mothers and fathers wanted to participate in clinical decision-making. Fathers in this study generally did not feel that they were involved in clinical decisions or that they had choices, nor that they necessarily had the expertise to be involved in such decisions. Overall, other than seeking information they seemed and were expected to be quite passive.

"I: so did the nurses involve you in his care and in the decisions?

*E: Oh yey they kept me informed if I asked a question but I know they've got to tell Mum or ask her. I just think that because they were nurses there was no need for me to get involved with that" (*Eddie, father interview).

"J: Um.. I don't suppose I had particularly input in to what was going on um but personally I will stand back- it's their job, they know what's going on.. I mean they make their recommendations, they do it for a reason so you trust what they're saying so I didn't have sort of too much of an input into what was going on... whether I thought I was given that opportunity – probably not" (Jake, father interview).

One father recalled his unsuccessful attempts to get the timing of his child's intravenous antibiotics adjusted to allow the resident parent a period of undisturbed sleep. Whilst the nurses understood his request, somehow it did not ever quite worked the way he wanted, suggesting that the nurses did not perceive it as enough of a priority to take action.

I did observe nurses involving mothers in decision-making in relation to aspects of nursing care such as medicines administration, but this usually took the form of the nurse making suggestions and the mother agreeing. Therefore nurses explained care to parents and expected their suggestions to be accepted and there was limited opportunity for parents of either sex to influence nursing care. If a mother had a particular preference, she had to be assertive for nurses to take notice and risked disapproval, as the following extract illustrates.

"Nurse at nurses' station with mother, planning medicines, who will be responsible for what – nurse has clear idea of what will happen and explains this to the mother and the reasons why things will be done, going through drug chart together, both being assertive, mother is definitely standing her ground as she wants to follow her own routine. Child has a chronic condition so they are frequent visitors.

Mother says "I know how to [...] I did a degree in business studies"

Discussion of how often the child is fed and how the feed is warmed. Mother clearly wants things done in a particular way. Although polite, there was some tension between them.

Mother joked 'can we have the pillows plumped and the bed turned down' " (observation notes 29).

My interpretation of the reference to her degree is that the mother felt she had to show she was intelligent and capable in order to gain some authority in the negotiation. Her joke was an attempt to defuse the tension and showed that she knew should would be perceived as demanding.

5.5 SUMMARY

In the domain of situated activity, nurses and fathers were continuously observing and judging one another. The specific relationship between nurses and fathers has not been described elsewhere. I have also shown how interactions between nurses, fathers and mothers were the arena in which power was exercised, predominantly by nurses and mothers. Mothers had power in relation to fathers arising from the perceived closeness of the physical bond between mother and child, but also in the discretion they were given by nurses in relation whether fathers appeared in nursing records. Nurses had power in relation to parents by virtue of their organisational function and position, as well as their professional knowledge and expertise.

My findings revealed discrepancy between what was recorded and what I observed. Yet from an audit or quality assurance perspective, which is valued currently within the culture of the NHS, the records suggested that care had been negotiated.

Chapter 6 The domain of social settings: the influence of structures, roles and routines

6.1 INTRODUCTION

The domain of social settings is concerned with institutions, both formal and informal; Mechanisms operate within this domain to maintain social relations, positions and practices (Houston, 2010). Social settings are the location for reproduced social relations, positions and practices (Layder, 2006). On the wards, a range of mechanisms were operating within this domain to influence fathers' experiences. In this chapter, I discuss these in relation to the influences of the informal institution of the family and the formal institutional processes and routines of the paediatric unit.

6.2 THE INFLUENCE OF FAMILY

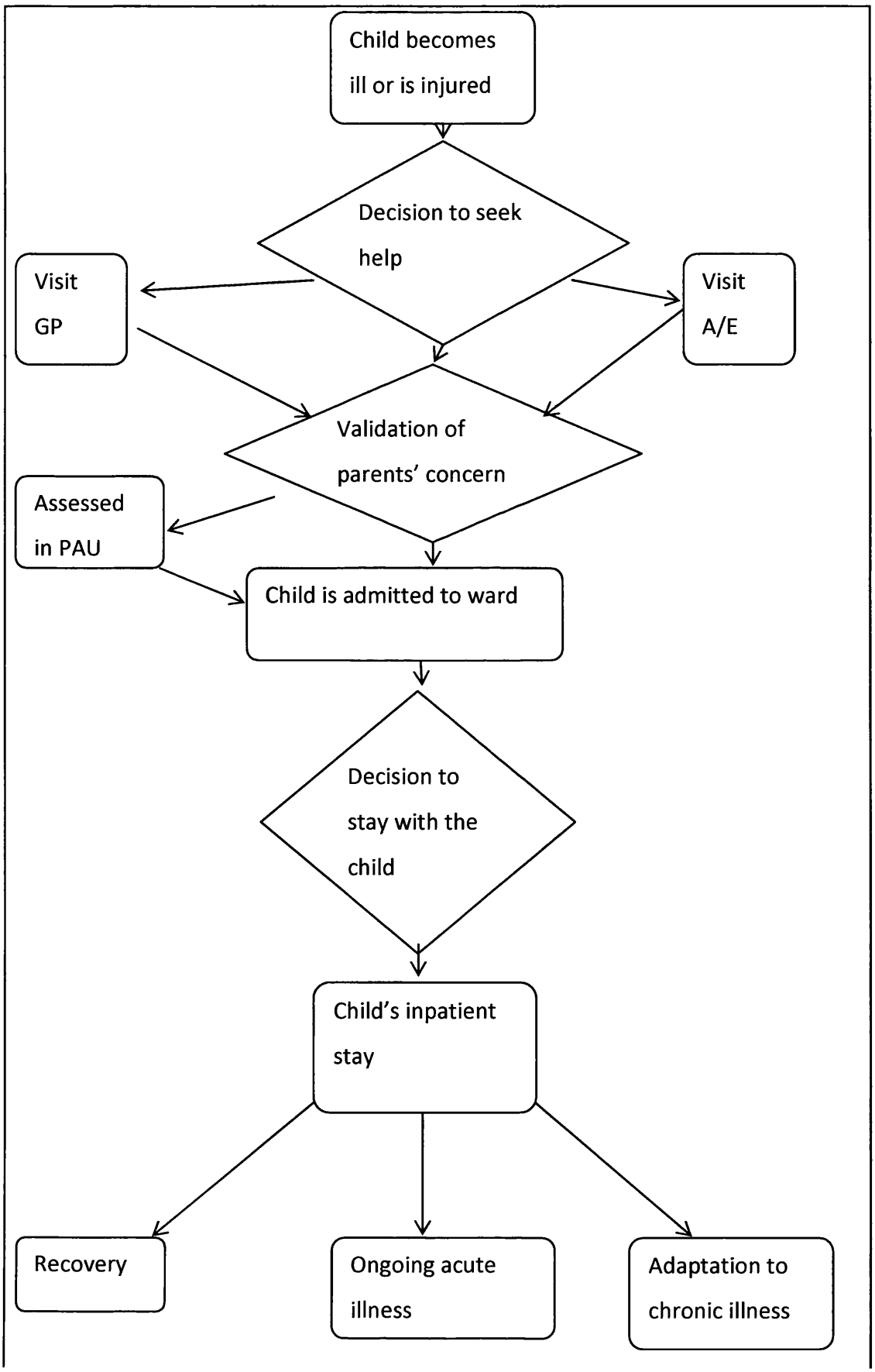
Fathers' experiences during their child's hospital stay were influenced by events around the child's illness and their family circumstances. These influencing factors included: events as the family recognised the need for and sought medical help, their family structure and the presence of siblings, the availability of a wider support network and the roles adopted by each of the parents within the family.

6.2.1 Recognising the need for and seeking medical help

During early interviews with fathers, I was initially puzzled that when I asked the father to tell me the story of the child's admission, fathers started their narrative from the point where the child was first recognised as being ill. I realised that fathers were interpreting my use of the word "admission" to mean "getting into hospital" whereas my meaning, reflecting my nursing background, was "a stay in hospital". However I also realised that for children and families, the stay in hospital

was part of a broader illness experience which included the child becoming ill, being referred to hospital, admission to the ward and continuing to recover after

Figure 6.1 The family's journey through healthcare



discharge. Fathers' understanding of their hospital experience was coloured by events in each of these stages, yet nurses showed very little acknowledgement of the existence of any aspect of parents' experiences and circumstances outside the confines of the ward.

Developing a diagram of the elements of the illness journey experienced by children and families (see figure 6.1) enabled me to gain understanding of how these events interacted and served as a reminder to me to bear the whole experience in mind.

Fathers' reports of becoming aware of their child's illness frequently began with accounts of how they were contacted at work and informed of the child's illness by the child's mother.

"I got a call from her that she's taking him to the hospital. But she took him to the GP first and um the GP straight away said ' Oh he doesn't look good and take him to the hospital' and er... so I... from work I went straight away to the hospital" (Barry in Barry and Ali, couple interview)

It seemed that mothers dealt with a child's illness when a GP was involved yet referral to a hospital was an indicator of more serious illness which warranted contacting a father at work who then accompanied the mother and child to hospital. Harry's experience demonstrated this well. His daughter had been unwell for several days and had been seen by the GP several times accompanied by her mother.

"so my wife went, I think for the third or fourth time to the GP and this time when the GP was going to send her back she made a complaint, [...] so eventually he agreed to a hospital referral so straight away I took her, I left work in the afternoon, took her to the hospital" (Harry, father interview)

Some fathers reported joint decisions with mothers to seek medical help; in these cases both the father and mother were with the child when the child's illness was thought to be sufficiently serious to need a medical opinion. In only one case was a father the sole person who initiated contact with health professionals, Chris, who took a call from his daughter's school reporting her accident, then took her to

Accident and Emergency. His role as the person who normally liaises with healthcare personnel has been discussed earlier.

Managing routine childhood illness therefore was part of the usual maternal role. Neill (2010) also found that the parents of acutely ill children at home saw mothers as having the responsibility for managing children's illness. She found that fathers became involved in the decision to seek outside medical help such as a GP visit. In my study, referral to hospital was perceived by mothers and fathers as a significant event which required the presence and involvement of both parents.

6.2.2 Family structure

Family structure influenced fathers' opportunity to be directly involved in the care of the hospitalised child. A key factor was the presence of siblings. The most common reaction of families with more than one child was for the mother to stay in hospital with the child whilst the father took the responsibility for the siblings.

"I mean I had the oldest one going to school as well, so I was doing my fatherly duties at home as well as at the hospital" (Harry, father interview)

Derek described in considerable detail, the complexities of caring for a well sibling going to school, trying to spend time with his wife and the ill child and continuing to work.

"bearing in mind that I'm away from M , trying to sort out a child at home who's at school , I've also got a day job I've got that I'm trying to do so I'm up at 6 o'clock, dealing with Phoebe [daughter] *trying to get her sorted out, explain things to her , make sure she's alright, packing her off to her friend, popping in [to the hospital], seeing him, seeing what's happening, coming back later and everything's changed. Then having to deal with work, back to the hospital, back to work"* (Derek in Derek and Maria couple interview)

None of the fathers interviewed who were resident had other children, although Frank's partner Tara did.

The findings of this study therefore echo those of Hobson and Noyes (2011) who found that fathers of chronically ill children, who were not normally primary carers, became primary carers for their other children when the chronically ill child was in hospital, enabling the mother to stay in hospital with the sick child.

The presence of older- teenage- siblings in the family enabled a father to spend more time on the ward as these older children shared the responsibility for younger well siblings.

"E: Well she was at home with the eldest, the eldest is seventeen so she was taking care of Shania [sibling] *for us so it was ok" (*Eddie, father interview).

Thus the admission of a child to hospital influenced many other family members, beyond the child and the parent present on the ward, yet nurses showed very limited recognition of this unless parents specifically brought it to their attention.

6.2.3 Support networks

Grandparents were also identified as sources of care for siblings, enabling fathers to spend time on the ward with the sick child, and some also contributed to the twenty-four hour parental presence on the ward maintained by many families. This enabled both parents to take a break from the ward together. The availability of grandparents to contribute care was therefore a significant factor influencing fathers' experiences, particularly for those whose children had extended stays in hospital.

"Yeah, the Tuesday and Wednesday M's parents came up, I went into school on the Monday and this is what's happening this is the problems and that I was going to have to take her out of school so I had to go through all the form filling cos I was, holiday forms and all of that, um ... then Maria's mum and dad came up.. picked up Phoebe [sibling] *and took her home"* (Derek in Derek and Maria couple interview)

"A: There was always one of us with him for the whole time.

I: What the whole twenty four days?

A:Yep Yep. It was either me or Sarah or my mum who spent, who did a couple of nights." (Adam, father interview)

This extract from Yannis shows how significant grandparents' contributions were for some families:

"I: And then, but you were also responsible for your other daughter?

Y: She was with my parents who we were visiting

I: Right,

Y: So they brought her in in the evening just to say hello that sort of thing

I: Okay so you weren't doing that sort of juggling?

Y: no fortunately. Well if we'd been doing that then... I wouldn't have spent much time in hospital at all. I mean if she had been ill here, 'cos we've got no family really or anyone here, it would have been much much more difficult." (Yannis, father interview).

Yet there were indications that nurses could perceive grandmothers as interfering rather than supportive, as the following comment by a nurse about a young mother during handover suggests.

"Mum and 2 grandmas are with him. Mum's mum keeps speaking for her " (Observation notes 28).

Griggs *et. al.* (2010) suggest that while grandparents have always supported the next generations, they may be making greater contributions at present than in previous generations. Yet historically, little policy attention has been given to grandparents' contributions to children's well-being. Very recently however, researchers have identified the significant contributions made by grandparents in relation to children with chronic illness and disability (Mitchell, 2007) and their well siblings (Ravindran and Rempel, 2010). My study suggests that some grandparents also make a significant contribution to family care needs during acute childhood illness. This is a topic that warrants further investigation.

Some families in the study identified other kin as also contributing to the overall care needs of different family members.

"I gave my other, the eldest to resident relatives to look after when I went to the hospital because obviously she couldn't go, she wasn't admitted" (Harry, father interview)

"T: Yeah but there was nothing I could do because I had [other child's name] *to think about as well so..*

F: Yeah he had school and everything didn't he?

T: Yeah, I literally phoned up my brother's girlfriend at half six in the morning, got her out of bed..

I: Did you? To come and

T: No I took [other child's name] *and the dog round to her at about half six in the morning. I would have phoned that night but my brother was out of the country and she's got a son of her own so I didn't want to put on them at quarter to twelve at night. So it wouldn't be fair to disturb* [other child's name] *either so..."* (Frank and Tara, couple interview).

Barry and Ali, as migrants to the UK had no family members available for support, so they did alternate shifts in hospital with their son whilst both continuing to work.

"A: and then just being the two of us, we don't have any family. We do have friends but of course they have their commitments and they're working as well. And we don't have granny or nan because they all are in [country of origin]*"* (Barry and Ali, couple interview).

Thus the admission of a child to hospital has effects on family members beyond the parents and the availability of a support network was a significant influence on parents' experiences, particularly fathers. It would seem that this is because a father's involvement in his hospitalised child's care is seen as discretionary by some mothers, fathers and staff whereas a mother's is seen as essential by the majority.

6.2.4 Roles

Within this study, the roles adopted by each parent in their usual family life were major factors in fathers' experiences. Some couples negotiated and actively created these, consciously or subconsciously conforming to societal norms or consciously rejected them.

Adam's son was admitted at three days old, yet he had a clear idea of his role from before his son was born:

"yes I think it was probably discussed about what a good dad I think I'm going to be (both laugh).. But I mean I wanted to be like as, as hands on as possible but I also knew that I was going to be, I was also going to be taking the male role in the relationship. I was I would still be going out to work after my two weeks paternity leave and Sue was going to be at home for as long as possible. That was discussed beforehand, and that's obviously still the case now" (Adam, father interview).

Cook *et. al.* (2005) found that maternal and paternal expectations before birth of paternal practical and emotional involvement with children were substantial predictors of *actual* levels of involvement. Adam's agency in making his intention a reality was evident from the extent of his direct care of his son and felt that this was recognised by the nurses:

"But I think that perhaps because I spent so much time there that I got to know them they realised that I was quite a.. I guess a fairly capable dad, rather than a stand back and watch dad which I think maybe blurred the lines of mums and dads." (Adam, father interview).

Although very involved in his son's care, and keen to describe the equality within the couple relationship, he saw himself as taking a traditional, masculine role rather than a co-parent.

"Although I guess I took the traditional male role where I spent less time there and more time than her organising other things" (Adam, father interview)

Some fathers did see themselves as co-parents. Zack and his partner, for example, both worked part time so that they could share parenting.

"me and my girlfriend Sue, we try to split everything and we do the same things. I don't think she takes the mum role and I take the dad role" (Zack father interview).

Thus my study shows how fathers were actively constructing their own fathering role rather than following an historical precedent.

Fathers who agreed to be interviewed may have had different attitudes towards fathers' roles with children from those who declined. Some fathers who I invited to take part in the study declined because they said they said they had little involvement or that the mother does everything. Of course, other fathers were not on the wards at all and discussion of their reasons for absence would be speculative.

However the extent to which fathers within the study were able independently to decide and enact their own personal model of fatherhood is open to question. One mother of a young baby I spoke to was emphatic in her views:

" 'as a raging feminist all my life I kind of insisted on us doing equal shares'. She spoke of them doing shifts – both at hospital and at home. She spoke of having "time off". She's on maternity leave at the moment so 'bears the brunt of it at the moment but evenings and weekends he does his share' (observation notes 29)'.

Mothers described themselves and were seen by nurses and some, but not all, fathers as the main carers for the child. Ferguson and Hogan (2004) in their study of child and family social work identified that some mothers were unable to see themselves as anything other than the child's main carer, and experienced ambivalence about including fathers. There was evidence from within my study that mothers do influence fathers' everyday involvement with their children, thus providing support to the notion of maternal gatekeeping proposed by Fagan and Barnett (2003) and Gaunt (2008).

Fathers spoke of breadwinning and providing as being central to their role in the family, whilst also being keen to portray themselves as actively involved in their child's care.

"I think that cos primarily Mums are still the main carers at home" (Zoe, nurse interview)

"But I think Mums are taken as the main carers" (Yvonne, nurse interview)

"Sarah had been looking after her all day, in fact the whole week so she wasn't working then because she was on maternity leave so she had borne the brunt of it, and because well Lucy being sick so regularly Sarah had a lot of stress associated with that so whereas me, I'd been at work so although it's a difficult situation, the only real impact it was having was when I came home and I'd feed her at 7 o'clock so she'd throw up everything all over me which is not very pleasant but it was fairly constrained" (Greg, father interview)

Although Harry asserted:

"My objective in life is to, now at this time is to support the family and that's all that I want – that's my ambition out of life to make sure my family is comfortable." (Harry, father interview)

elsewhere in the interview he stressed his "fatherly duties"- referring to child care.

Stueve and Pleck (2001) have developed the concept of 'parental voice', arguing that individuals' use of 'I' or 'we' in conversation about parenting experiences expresses internalised meanings about the degree of conjointedness in fathers' paternal identities. Within my study, fathers' sense of shared responsibility and involvement with their children was also demonstrated by their frequent use of "we" in relation to aspects of childcare, including breastfeeding.

"we could lift him out of the bed and put him on our lap for feeding, give him his milk, so that was our.. our responsibility if you like, our little bit that we could do was to keep him fed. And they, everyone was very encouraging as far as that was concerned and we felt we were taking just a little bit of that responsibility back, to keep him fed and watered really and that was our bit..." (Adam, father interview).

"obviously we were having problems with breastfeeding, and we asked for some help" (Ivor, father interview).

Thus nurses presumed that mothers were the primary carers and interacted with parents on that basis whilst the picture described by parents was more varied.

The families' normal earning/ providing roles also influenced fathers' experiences. The interaction between paid employment and fathers' experiences are discussed in detail in chapter 8.

6. 3 INSTITUTIONAL PROCESSES AND ROUTINES

The study wards can be understood as an institution operating within the formal institution of a district general hospital which itself operates within the institution of the NHS. In accessing the wards, families engaged with various institutions

within the NHS, each of which had its own processes. GPs and Emergency Departments acted as gatekeepers to specialist paediatric services.

In order to fulfil their specific function within the hospital and the NHS of providing medical and nursing care for children and support for their families, the wards had a number of processes, routines and rules. Those which specifically influenced fathers' experiences included: admission processes, medical rounds, nurses' handovers, the ward doorbell and the ward rules.

6.3.1 Admission Processes

As figure 6.1 shows, the pre –admission journey involved a number of stages. When the Paediatric Assessment Unit was open it functioned as a filter; all children referred by GPs were seen there with only those who were going to be admitted then going onto the wards, reducing the disruption to the ward work from new referrals. However the consequence for families was a prolonged process before admission to the ward and interaction with a greater number of practitioners. The effect of this prolonged process for families was that the decision to admit their child to the ward would often occur late in the evening or at night, after long periods of waiting at different stages in a process which in some cases lasted a whole day.

"B: Yeah, I thought I would not take a day off and make up time for it by working later in the evening. But the whole day was spent in the hospital. That's when they said "He needs to be admitted." (Barry, Barry and Ali, couple interview).

"D: yeah, then we got moved into the ward because the PAU closed

M :yeh it closed at 9 o'clock

D: and 'cos that closed we went into (name of ward) then basically we were told we'd be seeing a doctor within half an hour of us getting there into (ward name) then because of whatever happened[...] we didn't see the doctor then until..

M: 1 o'clock in the morning-)...

D: perhaps I don't know that bit (M laughs). Yeah, One o'clock it was before we actually saw the doctor but by that time I mean, I'd been up all day Phoebe [daughter] had been up all day, Phillip [patient] had been up all day and I was getting a little bit annoyed, angry because it was now getting to a point where he needs to go to bed, Phoebe needs to go to bed. We'd been up all day and they just seemed to drag their heels about what they were going to do and everything else. And then in the end they, I think it was about half past twelve or quarter to one they said "Oh he's staying the night" (Derek and Maria, couple interview).

Outside of the opening hours of the PAU, children referred by their GPs went straight to the ward. Once on the ward, these families could experience long periods sitting in the corridor waiting to be seen by a doctor. They experienced a disjuncture between the perceived urgency of the hospital referral and the apparent lack of urgency with which they were seen in the hospital. As discussed earlier, the corridor appeared to be liminal space- nurses took little notice of children and parents waiting there because they were not considered to be patients. Only when the decision to admit the child was made by a doctor did the child become a patient in the eyes of the nurses, meaning that a bed was offered for the child and admission procedures initiated.

One nurse showed concern about this practice,

"Well to be perfectly honest I did full time nights here for a while I was a li... a little bit... shocked by the attitudes towards parents who were left waiting I mean we have a PAU [paediatric assessment unit] which doesn't work at night so patients and parents can be sitting in the corridor for several hours, many hours and you're so busy trying to get round that what you're desperately hoping is that nobody dies in that corridor out of sight because as far as I'm concerned that will eventually happen" (Sam, nurse interview).

Sam later spoke of disregarding the rules in order to keep these not- yet-patients safe:

"I mean I used to do things that strictly speaking you were not allowed to do, like putting kids in to beds- we're told we haven't admitted them, yeah I don't care you know. We probably will do – it's just a case of washing the bed and changing the sheets- I'm happy to do that er. It gets the parents on side and keeps them where I can see them –it's got lots of pluses" (Sam, nurse interview)

As a very experienced children's nurse, Sam had the self –confidence to transgress the ward processes in order to meet children's and families' needs and the personal resilience to withstand the consequent managerial and colleague disapproval.

As a consequence of the routes to admission, the wards tended to be busiest with admissions from 1800 onwards, meaning that nurses were rushed to complete the administrative processes and that these processes were often delayed or disrupted by the shift handover which occurred at 1900. Yet this was key time for the families of children being admitted in terms of getting information, completing

documentation, establishing relationships and negotiating with nurses and making decisions, so could have a detrimental effect on initial care.

"it just felt as though, because we'd been waiting to get on the ward because they were busy, we probably just came on as a room became available, partly through a round or something so there just wasn't people around. So they came in and gave us everything we needed straight away but obviously not all the procedural details, just the essential stuff and it was also that time of evening when they were just changing over shifts so the person that we saw gave us everything but said that she was about to go off shift any way so... and then just handing it over to the next person" (Ivor, father interview).

It may also be a contributory factor to the incompleteness in nursing records discussed in chapter 5.

Thus the institutional processes combined to mean that children were often admitted when there were the fewest number of staff, reducing the time available for nurses to spend time with families. In addition, parents, although often relieved that the sick child was going to be admitted, could be dealing with very tired and hungry siblings, feeling tired and hungry themselves, yet they were being expected to remember information, negotiate their role in the child's care and be a competent co-worker.

6.3.2 Ward routines

The work of the ward was structured on rituals, routines and events which included the medical ward round, nurse-to-nurse handovers and the admissions and discharges of patients, and these all influenced fathers' experiences. The manner in which routines were structured served, albeit unintentionally, to marginalise some fathers, as Clarke (2005) also found in her inquiry into the experiences of fathers of children with cancer.

Ward rounds

The consultant ward round took place daily at 0900. Ostensibly, the purposes of the ward round were decision-making about all the patients' medical treatment and the teaching of junior doctors. The ward round was, for the majority of families, the only time that a child was seen by a consultant and therefore the only opportunity for parents to ask questions, receive information and participate in decision-making. It also had a ceremonial function, serving to re-enforce the

supremacy of the consultant and the medical hierarchy. There was often a palpable sense of anticipation before it began with the children all sitting on their beds waiting.

"1030 back on ward, which seems hushed with a sense of anticipation. Ward round is going on, parents are sitting next to their children's beds waiting" (observation notes 10).

Whilst the timing of the ward round served institutional purposes, in that decisions made could be acted on during the course of the day, this timing also presented challenges to fathers who wanted to be present and involved if they continued to work in "office hours" or had other children to take to school. If a father who had been unable to be present at the ward round asked to see a consultant, some nurses would endeavour to facilitate this, although not always with success. The general expectation was that if a father was interested in his child, he would have been present on the ward round.

Thus, ward rounds served the purpose of reinforcing the consultant's status within the hospital hierarchy, although some parents were ambivalent about how useful they really were.

"F: Yeah and what I would say is that the nurses actually tie it together. The consultants just come in and out but the nurses are the one who stitch it all together

I: you felt that?

F: Yes, if it was just you and the consultants it would be an unmitigated nightmare ..." (Frank and Tara couple interview)

One father whose child was under the care of two different clinical teams was frustrated by the way the teams worked independently of one another.

"She was conveying the information that was laid out in the morning, early rounds, then suddenly I'm there at sort of like in the evening after work, the next doctor comes round in the evening and makes a completely different decision, and I'm sat there and she's just told me that that's going to happen or that's going to happen, now suddenly that's... completely different" (Derek in Derek and Maria, couple interview)

During ward rounds, I observed that frequently, consultants would focus their attention initially on the child and then on the mother. As the consultant, registrars, junior doctors and sometimes medical students gathered round a child's bed, if a father was present, often he was relegated or relegated himself to the periphery of the circle. The nurses also said that this often happened.

"Sometimes fathers will sort of hang back. I'm thinking of ward round, you know on ward round sometimes when both parents are there, I mean generally it will be the mother who starts the conversation and asks questions about the child. I would say as a general rule that usually happens, although staff do talk to both parents when they're there." (Yvonne, nurse interview).

"I think on ward round if the doctors are in there and they're speaking to both the parents, that dad will probably take more of a back seat and the doctors would probably just look at mum and they wouldn't look at both of them, and mum would probably answer the questions and say yes or no to whatever the doctors want to do and dad will probably just go along with it." (Tracey, nurse interview)

If a father was present on his own with the child, he would be asked where the mother was, but on only one occasion did I hear a mother being asked where a father was. In this instance, the child had just been diagnosed with a long term condition.

"On ward round, consultant speaking to child diagnosed with a chronic illness, he asked about who else lived at home and then where father was. Didn't do this with any other families. He stressed the father needed to be included and taught about care as well as mother" (observation notes 7).

Thus fathers were frequently marginalised by institutional processes or staff communication patterns. Other fathers marginalised themselves from what was a key event each day. One father described how he wanted the "headlines" in terms of his son's condition but was not interested in the detail, although the mother was.

" well to be honest, when the consultant came round and said, oh he's okay and when I saw them and he said he's doing fine, I kind of switched off cos they'd discuss stuff amongst themselves and I'd only kind of mentally drift in and out of the conversation, whereas Tara would be there listening to them so I don't know if that had an effect .." (Frank in Frank and Tara couple interview).

And another father described standing back:

"Um.. I don't suppose I had particularly input in to what was going on um but personally I will stand back- it's their job, they know what's going on.. I mean they make their recommendations, they do it for a reason so you trust what they're saying so I didn't have sort of too much of an input into what was going on.. whether I thought I was given that opportunity – probably not ..but whether I would have stepped in and said it I don't know. (Jake, father interview*).*

Handovers

Nurse to nurse handovers took place twice a day between the nurses finishing a shift and those about to start a shift. These took place in an office, with the nurse in the charge of the finishing shift leading by giving a verbal account of the patients and events that shift to all of those about to start. This was followed by the allocation of patients to individual nurses, in turn followed by an individual

conversation about each child between the nurse who had been and the nurse who would be caring for that child. This conversation took place on the ward, behind the nurses' station, a no –go area for parents, and involved the nurses checking through the child's charts and sometimes discussing which aspects of care parents were undertaking. Parents were not involved or present during these exchanges. Thus handover between shifts could last up to an hour twice a day, during which time there would be minimal interaction between nurses and families.

Handovers were the only times during the course of a day that nurses were together as a group. Generally little mention of families occurred in handover, except if a family or individual parent was seen to be a problem in some way, although on occasion, concern for a mother's well-being would be raised. Thus they provided an arena for labelling and stereotyping both children and their families. This became evident over my time as an observer. Some comments also exposed nurses' expectations and judgements about parents in general in a way that was not expressed in individual interviews.

"Comments in handover this morning: 'mum's just phoned – they're decorating that's why they haven't come in, that's the first contact we've had , parents need to come in but they haven't been', 'mum's lovely, she doesn't go home, she's on her own, Dad left them'; 'there's loads of kids –that's why he came in and fell asleep'(all staff laugh)" (observation notes 31).

"During allocation I noticed looks between nurses and reluctance to look after a particular child, the sister gave herself this patient. A nurse nudged me and whispered 'we've got a difficult mother'. (observation notes 7).

"Sitting in handover this morning, the following exchange between nurses: [child's name] has got a stroppy mother"," 'I remember her' 'She didn't want him to have IVs –she wanted them oral' " (observation notes 8).

"Lots of judgemental comments about children and families today from the nurse handing over- some directed at me. This is unusual. The other staff did not join in or challenge – they just ignored. I wonder what effect my presence has on their reactions." (observation notes 16)

The extracts above also demonstrate that whilst nurses claimed to negotiate care, in fact parents were expected to be present and comply with what staff wanted to do, as Coyne (2007) also found. Parents in Lewis *et. al.'s* also identified a need to conform in order to establish and maintain good relationships with nurses (Lewis *et. al., 2007).*

Some nurses recognised that they were being judgemental of parents and showed awareness that professionally, they were not expected to be so, yet they did not overtly challenge the comments that were made.

"Comments in handover: 'he's horrendous'(his recovery from surgery is considered too slow by the staff) 'Mum's strange Dad's strange'. Direct looks at me from everyone. A senior nurse says directly to me 'not that we're judgemental or anything here – they're just weird' nervous laughter all round" (Observation notes 10).

"like when people are handing over, they may make a comment and you think well actually if you'd ever had children you'd know exactly what that's like and how that feels or the things that as a parent you worry about." (Wilma, nurse interview)

This is reminiscent of Callery's finding that nurses' sometimes difficult relationships with parents were always attributed to a problem with the parents rather than recognition that nurses might contribute to such difficulties (Callery, 1997 b).

Callery (1997 c) found that nurses were ambiguous about whether parents should be regarded by nurses as co-clients with their children and did not systematically assess parental needs. Whilst on an individual level, nurses could be responsive to mothers' needs, they did not systematically assess or anticipate these, rather they responded reactively. I did not see any instances where nurses anticipated or responded to a paternal need.

6.3.3 The doorbell

During my initial periods on the ward, the doorbell made a major impression on me. Whilst hospital staff had "swipe cards" which enabled free access to the wards, everyone else had to use the video entry system. The door was locked and a person without a swipe card had to ring a doorbell to gain access. The door could be opened remotely at the nurses' station once the person's identity was confirmed. The doorbell rang constantly and was often ignored, meaning that the person at the door could wait for long periods before gaining access.

"To get into ward without an ID badge, there's an entryphone system -phones at ward clerk's desk and nurses' station. When bell rings, staff check the identity of person at door either visually or by asking by phone, then press button to open door.

When the doorbell goes, if staff are busy they ignore it. It's as though they don't hear it. It rings ALL the time.

Most of the doctors ignore it even if they're sitting at the desk" (observation notes 5).

Nurses also appeared not to prioritise the doorbell over administrative tasks.

"Other nurses are at the nurses' station doing paperwork. Doorbell rings and is ignored. Nurse in charge organising paperwork, making sure patients have hospital numbers and working with students. Doorbell rings again 2 minutes later and is ignored.5 mins later, doorbell ringing, phone ringing, monitors alarming, nurses appear to be ignoring them all" (observation notes 12)

A senior member of the nursing team asserted that nurses did not consciously ignore the doorbell rather that they became so accustomed to hearing it that it ceased to register. During the later observation periods I realised that it no longer had the impact on me that it had in earlier periods, so I could see that her argument could be valid. It also became apparent that it was seen as the nurses' responsibility to respond to the doorbell, even though other members of staff such as doctors and teachers could just as easily perform this task. At one stage I realised that I too was expecting only nurses to respond. This recognition served as reminder to me of how powerful such institutional norms of behaviour can be.

"The doorbell rings and is ignored by the doctors. Bell rings again. Nurse leaves HDU to answer" (Observation notes 17*)*

Although parents appreciated the need for security, waiting for the door to be opened had a significant impact on parents' experiences, particularly non-resident fathers.

" then probably for the partner that's going home, just access to the ward because even after a few days, I could definitely feel that you'd walk up to the ward and walking up to that buzzer and you're just kind of going you start to feel yourself getting anxious because you're thinking, I could be or I could be here for the next twenty minutes er um and it's a really stupid thing but once or twice is fine but when you're doing it a few times a day, it just builds up, that , the walk to the corridor and you can feel there's kind of this slight anxiety building up as you get to that buzzer- it's just a doorbell (laughs) [...] It's probably not even 50:50 because most times it was fine but you only need one or two when you're waiting there. What's actually a two or three minute wait feels like an eternity when you're desperate to get in and you know a five minute wait just takes days when you're stood there with .. " (laughs and shrugs) (Ivor, father interview)

Anxiety over the wait to get back into the ward inhibited some parents from leaving to get something to eat or take a short break, so had an impact on their physical and psychological well-being.

Nurses were keen to stress the need to maintain security and that this was their role.

"Nurse told another nurse about a father who'd just complained because he'd had to ring the doorbell 4 x before someone let him in- she explained they were busy but had to check everyone's identity before letting them in but he was still cross" (observation notes 2).

Some acknowledged the impact that it had on parents but were unable to contemplate using an alternative- such as hotel style access systems. They assumed parents would lose swipe cards or pass them on to others. In fact, parents with children on the ward have a vested interest in maintaining the security of the ward for their own child's safety.

Furthermore, whether the doorbell system maintained security in reality was questionable for a number of reasons- checks of individuals' identities were often negligible and individuals who had been waiting to get in would often follow closely behind a person who had a swipe card thus gaining access without being checked by nurses. I did not see a single person be declined entry to the ward.

The doorbell had a symbolic function – indicating to parents their status as visitors on the ward despite the emphasis on partnership in nurses' talk, and their dependence on nurses, and for nurses it was a symbol of power and authority.

6.3.4 The ward "rules"

Within the wards there were many behavioural rules, some expressed explicitly in written information, others not. Again these served to maintain parents' visitor status or to assert managerial control over nurses.

Certain areas of the wards were off limits to parents and children; these included clinical treatment areas, storage areas, disposal areas, the main kitchen and the milk kitchen (where baby feeds were prepared and stored) and behind the nurses' station.

"A toddler wandered through the ward and behind the nurses' station. Mother looked concerned and awkward but didn't follow him behind the nurses' station and nurse gently led him away from the area- "this is for the nurses, you can't go there"." (observation notes 8)

Yet all children's records, including notes and clinical charts, were kept behind the nurses' station. In effect therefore these were off limits to parents too, even though one of the aspects of care which parents were frequently recorded as being willing to undertake was contributing to the maintenance of fluid record charts.

"All the children's charts are kept behind the nurses' station (in what is clearly the staff area, out of bounds for parents and children) so how do patients help with fluid charts etc?" (observation notes 11)

Nurses stated that areas were off limits for reasons of patient safety, but the effect was to make parents dependent on nurses for fetching things that parents needed which were stored in off limits areas. Yet parents can feel like a nuisance when they have to ask nurses for straightforward things (Teare and Smith, 2004).

"Grandmother came to nurses' station to ask for feed for baby. 5 nurses at desk. Nurse looking after that baby responded and took it to her 5 mins later, after finishing the notice she was preparing." (observation notes 6)

*"Mother approached Nurses' Station to ask for more milk for baby, nurse in charge asked the nurse allocated to her child to get it for her. This nurse gives a puzzled look and says 'She can't have any more' but gets up and goes to speak to mother" (*observation notes 22).

Sanctions such as public "telling off" occurred for those who broke the rules.

"Nurse loudly telling mother very firmly that she shouldn't be in the sluice, mother answers back that the other nurses let her in there, nurse replied very firmly that they should not." (Observation notes 19)

Thus, these rules served to maintain parents in the status of visitor and re-enforce nurses' position of power within the ward. However, one mother, a teacher, wanted the nurses to be more assertive in enforcing rules about not using mobile phones and restricting the number of visitors in the late evening. This mother stayed with her son at night on the open ward, going to work in the day, so for her the opportunity for sleep was important.

"there was one nurse wasn't there? She was on the night duty and she used to put the lights off, she made a point that all the lights were off and she was quite firm about using mobiles and she was very consistent, telling everybody you are allowed to do this, you're not allowed to do this and things like that, whereas some young nurses they seem unsure..[...] Because I used to get very annoyed in the ward at night because I'd had a tough day at work and I'd come and they , he's a little boy, he wants to sleep and then you'd have noisy, and chatting and they'd have the lights on and you were trying to get to sleep and.. So I used to find that, I used to be really pleased that she's on duty because I know that everybody goes to bed and the lights are turned off and if you want to have a conversation- playroom go do it there, things like that so..." (Ali in Barry and Ali couple interview)

So in enforcing the rules, nurses at one level, ensured the smooth running of the ward but at the same time increased parents' dependency on nurses. Their discretion over which rules they enforced and which they did not created uncertainty for parents and enhanced nurses' situational power.

6.3.5 Facilities for parents

There were limited facilities for parents on the ward. The only dedicated parents' facility was a very small kitchen shared between the two wards, where they could make hot drinks and this was subject to closure, making parents more dependent on nurses.

"As ward 2 is closed, so is parents' kitchen. Sign put up advising parents to ask nurse if they want a hot drink" (observation notes 6).

There was a very small facility for a small number of parents to stay off the ward in a unit which was across a corridor. Here, proper beds were available but no communal social space. This was used by mothers of children in HDU who were not permitted to stay next to their child due to lack of space. Parents were reluctant to stay here even though it offered greater comfort because of its distance from their child and the difficulties of access created by the doorbell. Nurses however could on an individual level, be responsive to parents' need for proximity to their child; parents of children in HDU were sometimes accommodated in empty cubicles on the ward, subject to having to move if the cubicle was required for another child and at the discretion of the nurses.

"B: Yeah and I think that the time when it was a bit difficult for you was when he was in the high dependency unit and they wouldn't allow you to sleep with him because it's the high dependency..

I: so they don't allow parents to stay in the high dependency area?

S: Yeah but that is understandable but even then the parents they can't be on the same ward, it's on the, the sleeping arrangements are on, on the other ward - the day assessment unit. It's quite a distance and though they say 'if there is something we will give you a call and we will let you know' with him, even the nurse said two days he was in there and we'd walk in to the ward and I'd see him looking at the door 'oh Mummy you are here now', so on the third day I said I want to, to be somewhere in the ward so they can call me between times and we can see how he's doing, and they, and then they said to me 'well then, all right you can, there'll be a place for me in the ward ' after I asked. And even the nurses said he looks very relaxed now, he's sleeping peacefully at night, otherwise he'd call me and wake up and he would ask for you so.." (Ali, Barry and Ali couple interview)

This extract also reveals how parents could be agential in their own experience, as long as their request was seen as valid by the nurse.

The opportunity to sleep in otherwise empty cubicles was also sometimes offered to mothers of children who had extended stays on the open wards, when nurses recognised that they were exhausted –again at nurses' discretion. Thus nurses

showed responsiveness to some maternal needs, though it is not possible to say whether or not they would have responded to paternal needs in a similar way given the tendency for exchanges between nurses and fathers to be relatively superficial and cursory, as shown by the extract below form Ivor.

"Family in cubicle 3 had been transferred to a cubicle because they have been in a long time and it was a chance for mother to get more sleep- showing sensitivity to mother's needs" (observation notes 15).

*"No-one treats you any different to the person who's staying, but.. as you probably know on checks and things, kind of cursory "are you ok , is there anything you need... "(*Ivor, father interview)

There was no parents' sitting room. Parents of babies in cubicles reported feeling isolated as they had nowhere else to go except their child's room and parents and children on the open wards could be disturbed by other parents talking. Some fathers, whilst recognising that it was not a priority, expressed a need for an adult space:

"the primary reason for a ward is to look after a patient so if you're going to spend money it should be on something that's going to benefit the patient so um having said, the health of the patient's family is significant because if the people around them are unhappy, going to become ill, they're going to pick up on it even young kids so if the people around them are worried and tense they do pick up on that so .. um.. probably just making it, not on the ward, but somewhere for the adults as well so that, almost like a breakout room where there's a comfy chair that you can sit in without having to go a long way away so that you can just get five minutes out because it does get stressful and tense" (Ivor, father interview).

When I visited the wards in the evenings, I often saw parents, whose children were asleep, using the playroom to talk or watch television, this necessitated sitting on chairs designed for preschool children. This was an incongruous sight which did not suggest that parents were valued at an institutional level.

Little thought appeared to have been given to parental needs beyond the need for proximity with the child, suggesting limited value for parents as partners at an institutional level. Inadequate facilities for parents have been identified in other studies (for example Hughes, 2007). Lee (2007) has argued that a lack of facilities for parents is evidence of a lack of respect for them as partners. Whist use of space is not within the remit of any individual nurse and space in hospital is always in demand- as parents themselves recognised, there seemed to be a need for advocacy by nurses on parents' behalf to improve this aspect of provision.

6.3.6 Parent-parent support

There was evidence that parents valued conversation with the parents of other children- both mothers and fathers and found such interaction supportive.

"a lot of kids similar age sort of, and they'd be in the playroom at the same time and you are all in the same situation, you don't want to be there but you are there and you just get on and chat and you realise you want a break from it, just to take each other's minds off it really" (Jake, father interview)

"Some mothers talking to each other about their care – the children had been in for the same few days with the same condition. Makes me think about peer support and how the lack of facilities for parents doesn't promote peer support" (observation notes 15)

For some fathers, talking to other fathers was important.

"that I was a bit ***isolated****.. it was difficult to tell how other people were being treated.. I think men, in that position find it easier to speak to other fathers naturally. S o I spoke to a couple of other fathers there"* (Greg, father interview)

The value of parent-parent support has been recognised previously (Darbyshire, 1994; Teare and Smith, 2004). Yet the lack of a communal social space for parents limited the potential for the development of supportive relationships with the parents of other patients, particularly for those of children in cubicles, who have been found to experience both less parent- to-parent and staff support (Morgan, 2010). I did not observe nurses promoting parent-parent support by the simple strategy of introducing parents to one another, suggesting that they had not considered this social aspect of parents' experiences whilst staying with their child.

6.4 SUMMARY

In this chapter I have shown how family structure, roles and circumstances influenced fathers' experiences. This in itself is not surprising, however nurses could utilise this knowledge to support families through their decision-making re family responsibilities in the early stages of a child's admission.

I have also shown how various aspects of the way the unit functioned were organised for the convenience of the staff and the hospital as an institution. When these were fixed and inflexible, these also disadvantaged families and created dependency. However discretion in rule enforcement meant inconsistencies leading to uncertainty for parents.

Some aspects of how the work of the ward was managed also performed a ceremonial function, maintaining social order and positioning through status, hierarchies and power- for both parents and staff. The need for nurses to conform to group norms became apparent through prolonged engagement in the field and a critical realist perspective on the social world; it operated as a powerful generative mechanism, at times over-riding the nurses' own individual professional values.

Chapter 7 The domain of culture- gendered practices in children's care

7.1 INTRODUCTION

The domain of culture refers to "the belief systems, norms, rituals, social practices, customs and tastes that generate meaning and social cohesion but also serve to divide and oppress" (Houston, 2010 p. 81), yet cultural influences may act at subconscious level as generative mechanisms on individuals' agency. I acknowledge that the effects of norms, values and social practices permeate all domains of social life; I have presented them separately for clarity. I showed in chapter 6 how ward routines served as rituals to reinforce the social order on the wards. These were overt aspects of the organisational culture, whereas in this chapter I consider more subtle but no less influential aspects of the organisational culture.

7.1.1 Gender

Gender has been defined as

"a multi-level system of social practices that produces distinctions between women and men, and organises inequality on the basis of these distinctions" (Wharton 2005 p 217)

Gender therefore is located in the world of social agency, as Connell (2005) asserts, exists at individual, interactional and institutional levels (Wharton, 2005), and within all types of social institutions (Connell, 1987). West and Zimmerman (1987) argue that people "do" gender, but do so in the presence of others who are presumed to understand what is being done. Therefore gender is an emergent feature of social relations (West and Zimmerman, 1987).

The family is identified by Deutsch (2007) as a potential source of women's power; therefore a study of fathers' experiences inevitably has to include reference to gender relations and power balances within couples. The ways in which women- mothers and nurses- exercised power at the interactional level were explored in chapter 4. Within the paediatric unit I found evidence that aspects of gender arising from the broader culture of contemporary UK society and the organisational

culture of the paediatric unit acted as generative mechanisms on fathers' experiences.

Within this chapter, I focus on two categories relating to gender which lie within the cultural domain, firstly in relation to the way in which motherhood was prioritised and then in relation to masculinity and femininity more generally.

7.2 PRIORITISING THE MATERNAL

Motherhood itself is laden with cultural meanings (Wharton, 2005), as indeed is fatherhood. It is beyond the scope of this study to explore these in detail here, but I do identify those which acted within the study to influence fathers' experiences. Vuori (2005) has argued that motherhood is seen by some as a societal duty whilst fatherhood is elective and personal. There was some evidence to suggest a tendency towards this perspective among some participants.

Findings demonstrating an organisational cultural bias towards mothers are presented in this section. I also explore the influence of mothers on the course of the study itself.

Professionals and parents of both sexes prioritised mothers' needs, mothers' views, mothers' knowledge of their children and the mother-child relationship in a number of ways. Mothers were seen as the natural carers for children; the mother-child relationship was regarded as special; mothers were seen as the source of authoritative knowledge concerning the sick child and the decision-makers in matters concerning the child and family.

7.2.1 Mothers are the natural carers

Even though professionals talk about partnership with *parents*, mothers were seen as the natural carers of children by many participants. Nurses said this explicitly in interview.

"Y: But I think Mums are taken as the main carers and it is that on the admission sheet really I think

I : Well that's what I've seen recorded . It's almost universally, is mum. And I just was interested to see...

Y: Do you think it's because we're conditioned to see like that? Or is it an historical thing?

I : I that's an interesting question, yeah,

Y: Because it's been like that for years and it still tends to be like that doesn't it? So it hasn't changed really." (Yvonne, nurse interview)

Thus, nurses demonstrated that they had internalised the belief that mothers are the natural carers to the extent that it shaped their behaviour and language without their awareness. Nurses' belief that mothers were the de facto carers of children was also shown by their tendency to explain fathers' presence by reference to reasons for maternal absence, both in interview and nurse to nurse handovers.

*"Comment in handover today: "his father stayed because mum is poorly" (*Observation notes 16).

"The dads being here sometimes it's because there are other siblings and the mum has to be there so most of the time that the case where mums are with the other children and I do find that's why dads are here because there are other children to be taken care of " (nurse interview Val).

Fathers were not usually expected to stay and care for the child unless there was a sound reason (as judged by the nurses, so for example maternal illness) why mothers could not or because he was "doing his share".

Many parents also saw it as "natural" for a mother to provide the care for the child and both parents and nurses expressed this by direct or inferred reference to "maternal instinct".

"E: Yeah, I think she wanted to stay. It didn't bother her to stay, I think it's just the motherhood .. My mum used to be there for me all the time even though my dad was there as well" (Eddie, father interview).

" If your child's in hospital I think it's easier for a mum- its an instinct isn't it – for mum to want to be here all the time?" (Tracey nurse interview)

However one nurse suggested that not all mothers exhibited this "maternal instinct"

"I mean sometimes you get fathers that come in and they're not interested at all, but then you can have mothers who are like that as well".(Yvonne, nurse interview)

Derek clearly felt that nurses displayed allegiance to the notion of "maternal instinct" in their interactions with him and his wife.

"D: I do because it's the mother, isn't it, the mothering instinct to look after the child, if you go back to caveman, the hunter gatherer, isn't it? Man's there to fight, woman's there to look after the kids

I: And you think that's what the nurses, that's how the nurses were behaving that they had that attitude?

*D: Yeah, absolutely" (*Derek and Maria, couple interview*)*

This essentialist understanding clearly puts fathers in a secondary position as carers. They were not in general seen by staff I spoke to as having an inherent desire to stay with the child and provide care, arising from their own relationship with the child. Rather, they performed a functional role as mother substitute, enabling, or in some nurses' views- allowing - mothers to take a break from their caring role.

*"V: I'd love to, I love it when the dads stay and I actually say that to them. I say "it's very nice of you to stay on the ward and let mum have the night off" (*Val nurse interview*)*

Cunningham-Burley *et al.* (2006) have argued that caring for sick children is a matter of gender responsibility and gendered identity. The notion of "maternal instinct" and the cultural meanings attributed to it may also influence how mothers judge themselves and are judged by others in their own performance of motherhood. Consequently mothers may feel pressure from others as well as themselves to stay with the child.

Wolff *et.al.* (2011) challenge the view that mothers are more attuned to children's needs than fathers. In their study of main caring fathers of chronically ill children, they identified that some fathers "seemed especially intuitive and responsive" to their children (Wolff *et. al.*, 2011 p. 153). One nurse in my study also felt that fathers of children with complex needs were different from the fathers of children with acute illness.

"But on some the dads appear to be... ... almost have a maternal instinct although they're not the mother " (nurse interview Wilma*)*

In expressing this, though she was hampered by an absence of a linguistic equivalent for fathers of "maternal instinct" to mean a paternal drive to care for children. In itself language then is suggestive of how fathers' positions in relation to their children are seen in society at large and the absence of a concept of masculine childcare equivalent to mothering. This may mean that fathers do not perceive an expectation that they will stay with the child, unlike mothers who perceive it as an

imperative, but rather see this as an aspect of care for the child to which they can *choose* to opt in.

However, nurses' views of fathers as, in general, secondary carers meant that fathers who were the lead carers or equal carers with a mother were seen as heroes. On several occasions nurses approached me to tell me about fathers who they portrayed as heroes because of their commitment to staying with and providing care for their child. These hero fathers described by nurses often had children with complex needs. Yet what the nurses saw as heroic behaviour by fathers was taken for granted of mothers. In this attitude, nurses reflect a tendency in broader society for involved fathers to been as heroes when mothers are not (Marsiglio and Cohan, 2000) and findings from research with Norwegian couples who were co-parenting, where the mothers attributed higher status to masculine childcare activities than their own mothering practice (Brandth and Kvande, 1998).

Zack, however, described a model of de-gendered co-parenting, both parents working part-time and neither playing a traditional maternal or paternal role.

"me and my girlfriend, we try to split everything and we do the same things. I don't think she takes the mum role and I take the dad role. We do both" (Zack, father interview)

In doing so, they as a couple demonstrate how, although gendered parental roles are a powerful societal structure, individuals can shape their own lives through their own agency, although this is limited by the expectations and behaviour of others. For example, Adam also emphasised how equal he and his partner were:

"I almost feel that the differences between being a mum and dad were.. faded really. They weren't big,. We feel very equal anyway and we felt equal whilst we were in there" (Adam, father interview)

He also used "we" almost entirely during his interview, thereby indicating a conjointed paternal identity (see discussion in 6.2.4) . and he himself said elsewhere in the interview:

"And whilst I was there [on the ward] and Sue was there and Sue was ***playing the lead role with the nurses..****"* (Adam, father interview).(emphases added)

Despite his assertion of equality, Adam was the father discussed in section 7.2.3 below who was seen by nurses as "being allowed" by the mother to stay in

hospital on his own with the child suggesting that this equality was restricted to within the couple relationship rather than more broadly. This demonstrates to me that although fathers might strive for equality in parenting roles, achieving this is not solely within the scope of their own actions, as society at present has a mother as carer as the default, though this may be beginning to change.

7.2.2 Privileging the mother -child relationship

Some nurses, fathers and mothers saw the mother-child relationship as qualitatively different and by implication inherently more important than the father-child relationship and this influenced the way in which nurses spoke to parents, often unconsciously suggesting that *mothers* were welcome to stay on the ward, rather than that *a parent* was welcome.

" Um... I think probably on our admission form which I think needs changing anyway, .. The parental bit needs to really be dads and mums, that sort of thing and I think kind of offer dads more of a chance to stay instead of the mums. I think maybe we say that- well "Mum can stay " cos probably that's the first thing that comes out of our mouths something like that" (Zoe, nurse interview)

"And when we admit patients we ask " well is the mum happy to do this and this and this?" and we forget about the dads and we don't say anything to them."(Zoe, nurse interview)

This privileging of the mother- child relationship was also evident among parents.

"I asked a couple how they decided who would stay with the child. The mother replied: "it was me. I wouldn't leave him. He [the child's father] knows I'd be worse if I was at home worrying" (observation notes 23)

The implication here is that the father would not be 'worse' or 'worrying at home' because his relationship with the child was not so close. Some of the mothers hinted that the children's fathers might experience similar desires to be with and care for the child, but felt that their own need to care for the child took priority. Some mothers acknowledged that this might be seen as unfair, yet they were keen to claim the privilege arising from the embodied special bond between mother and child.

""I do think I've shut him out a bit and pushed him away. 'Cos I gave birth to him and with breastfeeding and everything. I do feel that ***I have to be here*** *but I can see that it's not fair really, we've been talking about it... whether I should take a break but I feel I should be here"* (mother, Observation notes 35). (original emphasis)

"I asked a mother how she and the child's father had decided who was going to stay, she replied that she was breast-feeding so she had to, but her husband had said "he would have done half if he could" (Observation notes 6)

Many mothers can and do, express milk for their babies, so the biological imperative to be with the child was not as great as claimed, rather some mothers were using biological factors to legitimise their claim to be the parent who stays with the child. Thus they were exercising situational power. Gattrell (2007) has also identified how new- parent couples, in their negotiation of parental roles, located situational power within the maternal body.

However the privileged maternal position came with expectations and obligations. Mothers who did not conform to nurses' expectations risked being found wanting.

"There is a note in nurses' notes re mother of [child] – she has been unable to wait to see doctors on two occasions as had other children to collect from school" (observation notes 22*)*

The fact that a written record was made of this mother's behaviour was an implied criticism of the mother despite her circumstances, rather than an attempt to arrange an opportunity for the mother to speak to the doctor at a convenient time for her. I did not see or hear any equivalent reference to fathers not being able to be present.

Many fathers accepted the privileged position of mothers without question and were content that this was so:

"She thinks I could cope but she thinks ***the mother is the most important person*** *there at this time that the daughter needs and that's what, that's the key to it all to be honest um ...and I believe the same like .."* (Harry, father interview) (emphasis original)

"I approached a father of 9/52 old baby to ask if he'd take part, chatted for a while but he declined to take part as he works long hours. He was happy to chat to me on the ward though. I asked how he and the mother decided who was going to stay with the child. He replied 'It wasn't a decision, she had to'. He said nurses and doctors spoke to Mum first, and he put this down to mum being around all the time. He described how he clearly had no option to stay- because mum had to be there and only one parent can stay- but was quite happy with the situation. He'd gone home and done "the washing and stuff". He was very happy with how the nurses had spoken to them and dealt with him." (observation notes 28)

McNeil (2007) found similar views among fathers of children with a chronic condition, including those who had been primary care-givers for their children.

Other fathers felt that the father-child relationship was different but not less than the mother-child bond.

"during the day I wouldn't have the big contact with my daughter because I'm at work and Sarah's looking after her, we have a slightly different emotional response to our daughter, we see it from slightly different angle" (Greg, father interview)

There was one exception to fathers' deferral to mothers. Frank asserted his desire to be with his son over that of the baby's mother.

"I: Okay, and how did you decide who was going to stay? I mean, how did you decide who was going to stay with him, how did you work that between you?

F: Well, er ...

T: Well you insisted to start off with

F: yeah, so the first night was fine because he wasn't seriously ill at that point. We got discharged and the second night I took him back in and there was a reason why I took him back in

T: cos I had to stay home with (other child's name)

F: So (other child's name) was already in bed so Tara had to stay home with (other child's name) so I took him in the second night, so Tara took the next two nights to balance and then.. I did the next two, because of Fathers' Day and stuff and I wanted to be there so I mean, you would have done more.. it's just that I wanted to do it so .." (Frank and Tara, couple interview)

Tara clearly perceived that Frank insisted on staying in hospital with his son, although he appeared reluctant to say this. Although Tara "took the next two nights", it became evident later in the interview that Frank had needed to return to work at that stage. Unusually though, Frank had brought the baby to hospital during the night on his own as Tara had an older son (from a previous relationship) asleep at home. Therefore Tara had not been in an initial position claim maternal privilege and as he was on his own, Frank had not observed staff prioritising mothers, so may have been unaware of the expectations.

Thus, mothers were exercising power which derived from the cultural position of the sanctity of the mother-child bond, and were condoned in doing so by nurses who presumed that mothers would stay and unconsciously expressed this in their interactions with parents.

7.2.3 Mothers as and in authority

Throughout observation and interviews it became apparent to me that mothers were seen as both the source of authoritative information about the child and were the ones who had the authority to make decisions. This reflects the broader position in society of women vis-a vis their children.

Nurses described how they either automatically asked mothers for information about the child or how if they asked fathers, fathers either did not know or had to refer to mothers.

"It's easier to ask the mum questions if she knows mostly what's happening with the child" (Una, nurse interview)

" Um just that I think that fathers are often viewed as not knowing very much about children and I think that's... probably a wee bit old fashioned but um it's still true even within my family" (Sam, nurse interview)

"I find if I try and talk to the fathers some of them are quite good and they know a lot about their child and they're quite happy to take part in their child's care. Other fathers they know the mum knows more so they say it's best to ask the mum or they don't want to be too much involved or they just come and visit after work and the mother ends up staying." (Una, nurse interview)

Some fathers agreed that mothers knew most about the child:

"I approached five fathers today and invited them to be interviewed - one refused saying 'it's not really me – it's his mother who does everything, I'm not the one to talk to' "(observation notes 35).

During interviews with fathers, it was common for fathers when speaking to me, to turn to mothers for confirmation or correction of the details of the child's care.

"I: So how long was she in for?

J: She was in for three nights? [looks at Sam his wife to check, she says " mmm"].Yeah three nights in the end." (Jake, father interview)

During other interviews with fathers, mothers interrupted, uninvited, to, as they saw it, correct the fathers' account or provide missing details, suggesting they saw their own interpretation and recall of events as the definitive one. The following are typical examples, showing that fathers deferred to mothers' versions of events:

"D: yeah
M:No that was the paediatrician they said they said they'd get the orthopaedic come first thing in the morning
D:Paediatrician yes
M:Then they said they'd get the orthopaedic to come first thing in the morning so obviously they were
D: Yeah so basically that was it- the paed turned up and he said he needs to see the orth [orthopaedic surgeon*] so that was it. I then end up leaving at half past one in the morning, driving another 20 miles. Phoebe [*sibling*] was absolutely in tears, trying to calm her down and get her home to bed. I had the next day off*
M: No you didn't-
D:. No I didn't. I had to work didn't I?
M: You went to work you had to, you had a big meeting
D: That's right I did. Yeah" (Derek and Maria couple interview)

"G: my wife took her in on er the Friday evening well, well I was away at the time so I got a phone call ...

[S enters from other room]
S: Sorry just to say- I couldn't wake her up, that's why I called 999..
G: Sorry yes, that's right (laughter) .. My wife always tells me what goes on (laughter) (Greg, father interview)

Thus it would seem that mothers, as well as being seen by nurses and fathers as the source of truth concerning the child, saw themselves in the same way. Neill (2010) and Callery (1997 b) have discussed how mothers can feel health care professionals are sometimes dismissive of mothers' specific knowledge about their own child, so there is potential for tension here. If that is the case, then fathers would be at a significant further disadvantage in having their concerns heard.

There was a general view that mothers were the decision makers, so as well as being *the* authority on the child they were *in* authority.

E: Oh yey they kept me informed if I asked a question but I know they've got to tell Mum or ask her (Eddie, father interview)

Mothers also automatically assumed the position of decision-maker.

During a conversation with a couple she described how she ***had*** *to stay with the child, then added "Not that I don't think he'd be able to... What do you feel about it?" (to father)" He replied "You make the decisions" (*Observation notes 23)

*"Student and Staff Nurse re father "he stayed on his own last night-that's the first time he's [the father] been left on his own" (gently mocking tone, laughing)" (*observation notes 4)

The implication of this exchange between nurses was that the father had been deemed competent by the mother to care for the child overnight without her- therefore he had to satisfy her of his competence before she would leave him to care for their child. This clearly relates to the notion of maternal gatekeeping discussed in chapter 2.

Some mothers also attempted to influence what happened on the ward when they were not there. The quotation below from a couple is an example; the mother stayed overnight and the father stayed during the day so that she was unable to ask questions of medical staff directly.

"B: Well I used to, you know when she came back from work I would for half an hour fill her in on what happened during the day what did the.. the surgeons used to come once a day first few days and then it was every few days and I used to fill her in and in the morning when I used to go and before the evening she would say so what happened last night and

S: and to point out "these are things you need to do and these are the things you need to ask the surgeon when he comes round" [laughs]

I: Okay

S: and you know how mothers are.. [laughs]

I: so you gave him a list of things to do?

S: yes [laughs] (Barry and Ali, couple interview)

Many mothers perceived that they had continuing authority and responsibility beyond the hospital to what was going on at home, even if the mother was staying in hospital.

"In conversation with a mother resident on the ward today, she described how she was on maternity leave at the moment so in relation to caring for the baby, 'bears the brunt of it at the moment but evenings and weekends he does his share', although she still does the 'thinking' on her time off. She said:

'Even here- .. I go home and do the washing and vacuuming, he goes home and sleeps and watches football' (observation notes 30)

Nurses saw domestic responsibilities as naturally falling to the mother- if not directly performing tasks, at least ensuring that they were done.

*" Yeah cos I think if a mum was to go out you'd say "make sure he's had a bath and brushed his teeth and had dinner". They sort of get told what they have to do because mum wants to make sure that it's done" (*Tracey, nurse interview).

However the non-resident fathers I interviewed frequently claimed these domestic responsibilities as their own. I gained the clear impression though, that many non-resident fathers were being directed by mothers.

*"And obviously one of her objectives was for me to look after Nadia, the eldest daughter so obviously that was her concern that "are you looking after her, are you feeding her? Making sure she's going to school" you know all these kind of things" (*Harry, father interview*)*

It appears that some mothers were reluctant to relinquish responsibility for domestic labour, even when they were not in a position to perform this themselves. This may because of their own gender ideology, such responsibility may have been central to their understanding of the maternal role and identity. By maintaining hold of this responsibility, mothers were maintaining their positions of power and authority within the family and home. In not relinquishing this responsibility however, they increased the pressure they were under.

7.2.4 Organisational gender bias

Within the paediatric unit, it was taken for granted by staff that it was mothers who staff should be dealing with, yet the staff seemed largely unaware of this. Many, but not all, fathers appeared to presume that this was how it would be and were quite satisfied with the situation.

"I approached a father of 9/52 old baby to ask if he'd take part, chatted for a while but he declined to take part as he works long hours. He said nurses and doctors spoke to Mum first, and he put this down to mum being around all the time. He described how he clearly had no option to stay- because mum had to be there and only one parent can stay- but was quite happy with the situation. He'd gone home and done "the washing and stuff". He was very happy with how the nurses had spoken to them and dealt with him." (observation notes 28)

" nurse talking to mother- nurse is giving discharge advice, nurse is kneeling on the floor talking to mother across the bed. Father is sitting on chair to one side. Nurse is focusing all her attention on the mother, whilst including the child" (observation notes 27)

"and when I was there and they were talking to M and talking to Philip [patient] *I 'd be just the person sat there in the corner"* (Derek in Derek and Maria, couple interview)

This was particularly evident on ward rounds and Tracey shows how this was a persistent aspect of the culture of the wards.

*" Well, on ward rounds really, say if both parents are there the doctor will talk to the mother and the dad will still be stood there but they won't even like make eye contact or even acknowledge him really so everything gets told to the mother and the dad gets pushed out really." (*Zoe, nurse interview)

" Well I suppose, everybody if mum's there, like the doctors, you tend to .. you do tend to speak to mum more. And maybe we should be speaking to both of them and then .. yeah, .. we should speak to both of them not just one of them I think. But I think it's one of those things that you just do ...like sort of like habit ... so you see other people do it so you do it as well. Like if the doctor's gone in there in the morning and spoken to mum and it's mum that's said yes and mum that's asked all the questions then you tend to sort of go back in there and you know sort of to mum, "did you understand that and everything are you happy with all that?" and make sure that sure that she understands it's because it's her that's said "yeah that's fine, let's do it" and dad hasn't sort of said anything .." (Tracey, nurse interview)

Yvonne agreed but suggested that in doing so, doctors and nurses were following the lead of the parents.

"I think as a whole we tend to give information more to the mother than the father. Sometimes fathers will sort of hang back. I'm thinking of ward round, you know on ward round sometimes when both parents are there, I mean generally it will be the mother who starts the conversation and asks questions about the child. I would say as a general rule that usually happens, although staff do talk to both parents when they're there." (Yvonne, nurse interview).

Fathers however might have been responding to all the cues in the situation suggesting that mothers know, or are taken to know, the child best and are best-placed to make the decisions. Wolff *et. al.* (2010) found a similar bias towards communicating with mothers among health care professionals in their study of the experiences of fathers who were main carers.

Derek felt particularly strongly about this, describing how a doctor had begun a conversation with him when he was on his own with his child, only to transfer his attention to the mother when she appeared, mid-conversation.

"Yeah, you're having a conversation, starts talking and he's explaining a few bits and pieces and its suddenly you know it's like me sort of, sort of explaining and now and saying nah nah nah and I'm like (turns away and directs words to imaginary person) and like 'what are you '.. (Maria laughs).You know what I mean it's sort of -as if you're a spare part, completely inconsequential who hasn't got a thought or an idea . And as well because you're not there, because you've got a parent there who's there all the time its like – you're the one who cares and is concerned you're the one who's here all the time so you've obviously got all the time for your son or your child, you're husband or dad who is only here now and again so you, you've got no thoughts or no feelings about how your son is doing .." (Derek and Maria couple interview)

Staff showed care and concern for mothers' well-being, by for example comments in handover or bending the rules regarding the use of cubicles to allow an exhausted mother to sleep, but I did not see or hear that happening for fathers as individuals, although nurses, particularly the more experienced, did on occasion show concern for couples.

"Handover from nurse in charge – 'I'm late 'cos I had to find someone to have my baby- I've sent his mummy and daddy to get something to eat and promised I'd baby sit'.

A commitment to the parents to look after the child – which she felt was more important than handing over, also shows how some nurses are making assessments of parents' needs, even though they don't usually discuss or document it. Is this a trait of more senior nurses? " (observation notes 39)

Some fathers clearly did not feel cared for and some nurses agreed that fathers got little attention, although this may have been a consequence of fathers' own efforts to appear strong (discussed in chapter 4).

"I: ..Um.. ..I don't know I don't feel that there was anything, ... I was ...looked after in any way um...I..Certainly in our situation where the child is the one that's admitted and the mother's not well and staying, you can't really go "Oh actually I don't feel very good about this (laughs) So there's kind of putting on the .. front and you don't need the same sort of care as the person who's staying but you probably do need something...I" (Ivor, father interview)

"I had a conversation with a couple, mother said "I'm the one getting the attention but it's harder for him. It's just as emotional for him but I'm the one who the nurses ask if I want a cup of tea" (observation notes 34)

"In handover, discussion of emotional well-being of mother of a baby with a genetic disorder, no mention is made of father's emotional wellbeing" (observation notes 1)

*" Um I think a lot of care is provided just to the mums and the children" (*Una nurse interview)

Yet there were many "thank you cards" from discharged patients and their parents displayed on the wards in which comments such as "thank you for looking after us all" and "thankyou for looking after me and Mummy and Daddy" were written. Mothers who had themselves felt cared for may have been speaking for the family as whole when writing these, or they may have been responding to a cultural norm of politeness.

7.2.5 Mothers' influence on the study

Early on in the course of the study, I realised the power and authority of mothers influenced me as a researcher directly. During the early days of data collection, I took care to avoid interrupting couples who might have only short periods together if they were caring in shifts. Therefore I waited until fathers were on their own before approaching them to invite them to take part. If mothers returned while I was speaking to the fathers, I was regarded with suspicion, and although I would then explain again what I was doing, none of these fathers agreed to interview. I therefore changed my approach, deliberately approaching couples together and explaining the study to them both together. More fathers agreed to take part following my change of strategy and I was often given (by fathers) the mother's mobile telephone number or email address as the point of contact with the father! Therefore I experienced a form of maternal gatekeeping.

Also, I had not intended to conduct couple interviews as part of the study, but in three instances mothers loitered on the edge of, then spontaneously joined, the interview. As a guest in their family home, I accepted this but tried to maintain a focus on the father's experience.

So, fathers' experiences were shaped in part by the expectations and positioning of mothers in society generally and on the wards. The positioning of mothers

discussed here is one aspect of gender culture in society and it was evident that other aspects of gender were also influential.

7.3 MATTERS RELATING TO MASCULINITY AND FEMININITY

Within this study the other aspects of gender that most influenced fathers' experiences were their own and nurses' gender ideologies, the notion of children's nursing as a gendered practice and the wards as a feminised place.

7.3.1 Gender ideologies

Gender ideologies, that is individuals' internalised beliefs and norms concerning men and women, masculine and feminine, were revealed in interviews and clearly influenced fathers' experiences, both positively and negatively. I discussed in chapter 4 how fathers' actions were prompted by gender identity and their views of the father role as protector and provider, and here I focus on aspects of femininity and masculinity more generally.

Women were seen by fathers in the study to be caring and as responding to the emotions of others. The extract from Chris's interview below reveals how powerful and significant his understanding of the role of a woman, both as a woman and a mother, was in his own and his child's experience, yet this is based on an everyday exchange about school, during a brief but for him meaning-laden interaction.

*"I was very **pleased,** I'm not sure who she was she might have been an anaesthetist, she might have been a theatre nurse, but whoever she was she was a lady and she, she asked all about what school she was in and she was 'Oh I've got 2 children in the school opposite' and that helped, helped us both relate to her. I certainly got some comfort from the fact that it was all a well-oiled machine but that in the middle of it there was a mother*

I: Right

C: who cared about her children and that actually helped me quite a lot because I did find it incredibly difficult to... leave.. her there...

I: uh uh, mm,

*C: .. that moment –to **leave her completely in other people's care**. I know it was only a minor thing but it was still significant" (*Chris, father interview) (his emphasis)

The nurse involved probably had little awareness of the effect she had on Chris. The comfort Chris felt, arose not from this woman's clinical competence, actions or

words but from his culturally based beliefs about women, and mothers in particular, and he was clearly aware of this himself. Yet he also valued the objectivity he felt the male anaesthetist displayed.

"yeah... well... I was trying to think how I felt and clearly I was very aware that I was very sensitised at that point, when she was in pre-op ... room... er .. and .. and.. yes it was important to me and it was important to x as well because I wanted the staff to get on with her, to see her as a little girl, not a patient, not just a patient and on the one hand I want them to be clinical and efficient and if you like .. objective and not let certain feelings get.. I suppose if you like I ... this sounds very sexist but ... I certainly ascribe that to the anaesthetist, he was very matter of fact, clearly knew his stuff and I respect ... his judgement and his profession but I was mighty ***pleased*** *that there was a woman there who I thought understood,* ***cared about me and my daughter*** *as a person."* (Chris, father interview)(his emphasis)

Some fathers thought that mothers - as women and mothers- needed to see the compassionate side of nurses more than fathers did.

"Mothers and fathers and nurses, how they need to treat both. I think a mother needs much more er compassion much more er . Nurses need to be transparent in the care they provide because I think what they, a mother in hospital sees, sees impacts as much as the care they actually they received, you know what I mean, they need to see the nurses coming across as compassionate. That could be over half the job done for a nurse, do you know what I mean, if they see as cold and calculating but they're doing an efficient job [...] They're there on an emotional basis, no professional capacity whatsoever so if a nurse does a 100% professional job that impressed her matron or someone like that, unfortunately that doesn't translate to a mother who is only there with only emotional thoughts in her mind and if the nurse did the job on a caring basis which may not satisfy the matron, it would satisfy the mother I can tell you that. And for a father you know, I can only speak for myself, I um ..I'd like to see the nurse being caring towards my wife. If they're cold and calculating with me, you know they're just doing a professional job but that's what I'd expect you know what I mean (Harry, father interview)

Harry's use of the term "professional" to suggest dispassionate, clinical and efficient and at odds with being caring surprised me initially. However, on reflection it connects with the historical debate about professionalisation within nursing itself–seen by some as moving away from the origins of nursing in feminine caring and is reflected in Jolley's discussion of children's nursing's lost traditions of loving and maternal care (Jolley, 2011).

Fathers thought that men were less likely to talk about their feelings and this related to being masculine, although I have shown how willing those who I interviewed were to do so with me. There was also a perception that staff might think men needed different support from women when they may need the same.

"Um.. it's probably a man thing to bottle it up but errr and probably quite masculine to.. try and keep it bottled up as long as possible [...] But men I would guess are more susceptible to bottling things up anyway and.. quite often.. probably wouldn't even do the talking about it outside. Err.. I'm possibly

slightly different cos I'm quite .. aware of the psychology and the.. needs that you need for good mental health so I knew that I did need to go out and you know just let it out." (Ivor, father interview)

"maybe some people are also.. very good at saying what they need, perhaps men are not very good at saying what they need .. so.. I don't know." (Greg, father interview)

"I always struggle to be honest with the er divide between men and women on what they actually need. I think it just depends on your own psyche .. ..However there might be a perception from medical staff that women need different things than men. You know I.. feel .. I could have done with a bit of reassurance." (Greg, father interview)

Earlier in his interview, Greg had described superficial interactions with nurses, as did other fathers. This was consistent with what I observed, which was a culture of predominantly limited, functional, interaction between nurses and parents of both sexes, but particularly fathers, although there were exceptions.

"Nurses are polite and friendly to parents- responding to parental requests; interact with children when delivering care but not otherwise." (Observation notes 3)

" I don't see nurses and parents just talking –the talk I between them is all instrumental" (observation notes 15)

"you're just there as a parent and that was it there was no other purpose for you other than that you're there for your child," (Jake, father interview)

" Yeah (same nurse's name) would do that, she'd come and "budge over", and sit down, and that's what you want. You know she'd sit and then... (nurse's name) was about the one and only one, I mean Maria and I would , if I was there, she'd come over and actually talk to me, I mean she'd talk to me over you (to Maria)! So I used to walk in and see (nurse's name) and I knew I'd be alright, but others it was just like that (snaps fingers)" (Derek and Maria couple interview)

So, even if fathers did want to talk, the communication culture within the wards limited the possibilities for doing so. One nurse perceived that fathers spoke to nurses because they wanted information whereas mothers would just "chat".

*"I think they have different needs because mums tend to like to talk with you alot about what's going on. Fathers want to know what's happening, the specific details, why are they on this medication and what does it do whereas mothers tend to just talk to you, they want someone to chat to and they're just going along in the day sort of thing" (*Una, nurse interview)

Callery (1997 c) found that parents presented unpredictable demands on nurses' time and therefore there was need to contain these demands. The nurses' limited and functional communication with parents, and particularly fathers, that I found may therefore have been a strategy to achieve this containment.

7.3.2 Children's nursing as a gendered profession

Approximately 95% of children's nurses are female (Robinson *et al.,* 2006) and during the course of data collection, all nurses working on the wards were female. Fathers saw nursing, and children's nursing in particular, as a feminine role.

"I still expect nurses in the first instance to be female. When I imagine a nurse it's a female nurse. So I wasn't surprised" (Adam, father interview)

In its beginning nursing was a specialised form of domestic work in which female hospital nurses did for patients what women did in the home for family members (Oakley, 1998), therefore nursing has historical and ideological links with femininity. Gray (2010) found some student nurses (not children's nurses) likened nurses' caring for patients with mothering a child. As women caring for sick children, many of them mothers themselves, it is not surprising that the nurses in the study attached such great significance to the maternal role. However, it is perhaps surprising that as working women (and mothers) themselves, they did not show greater understanding of the pressures the mothers of their patients might experience.

The implication from some fathers was that they assumed male nurses would be gay. Fathers did not express this overtly but their hesitation as they spoke suggested to me that they were trying to find socially acceptable ways to express this.

"Int: and do you think it would make a difference to that if there were more men around as nurses on the ward?

I: ...Umm...possibly... but I think again it's quite a difficult proposition um, because, not being very politically correct, most of the male nurses certainly in paediatrics, tend to be quite effeminate so er.." (Ivor , father interview)

G: I don't think I saw a single male nurse actually er ... I think you need a father on the ward, so, having a male nurse – fine but the difference is by being a ***parent*** *that's what really makes a difference because er...*

I: Ah, okay

G: Er and I think.. some of the nurses er.. they may have been parents, some of them were.. but if it had been a ***father*** *–a male nurse who's got children, especially young children that may have been different."* (Greg, father interview)

As a consequence, fathers as heterosexual men themselves said they would not find the presence of male children's nurses supportive:

" I mean I notice it and I'm not a particularly manly man in a lot of senses, but if you were quite butch and quite aware of it you wouldn't really feel, I can understand that you wouldn't be comfortable offloading to um a more feminine- you wouldn't be comfortable offloading anyway and I don't think having an effeminate man would help you to offload (laughs)" (Ivor, father interview).

There's an interesting dichotomy here, between fathers' commitment to active, hands on child care as part of their own fathering and therefore masculine identity and their imagined masculinity of men who do the same thing on a professional basis. It appears that chilcare is an acceptable part of current hegemonic masculinity only in relation to one's own children.

7.3.3 The wards as a feminised place

Within the wards, no images of fathers or mothers were displayed. The walls were used to display children's school work and thank you cards from ex patients. There was a parents' noticeboard which displayed "the rules", information about a variety of services such as café facilities and shops within the hospital and a breast-feeding support group. One bathroom and toilet was available for parents' use, in addition to those en-suite facilities in cubicles. No shaver points were available.

Robb (2010) has argued that child care environments such as nurseries are feminised, desexualised environments, and that is how I would characterise the wards. Doucet (2000) identified that fathers who were primary carers for their children felt uncomfortable in what they perceived to be feminine places- such as the play group, nursery and at the school gate. They felt they lacked a shared culture with the mothers and struggled to fit in (Doucet 2000). It seemed to me that the men who were resident on the wards were possibly those who were most at ease in the company of women and the gendered space of the wards.

One father who had been resident in a cubicle on the ward identified the strangeness of the ward environment in relation to sex and gender, recognising the embodied aspect of his experience and acknowledging that this could have an impact on the nurses as well as himself.

"I noticed it because it was unusual for me to be to be in a room which is kind of my bedroom and for a girl to walk in the middle of the night. It's just that was odd...but there was a reason for it(...) I would say the only strange, the only odd thing would be when I was there overnight and you've got female nurses coming into the room, and I'm there. And well I don't mind 'cos if I'm asleep I'm asleep- I'm not really bothered but I don't know whether that makes nurses feel any different about going into a room with a bloke sleeping there, half –dressed, so I don't know. It was always in my mind that I must always have enough clothes on for instance" (Adam, father interview)

Perhaps nurses' discomfort around men –particularly in cubicles at night- explains fathers' descriptions of their very brief and strictly instrumental contact with nurses. The embodied aspect of the relationship between female nurses and fathers was not discussed by any other fathers or nurses. This embodied aspect of working with parents has not been addressed elsewhere in children's nursing research, yet is evidently a topic that warrants further investigation.

7.3.4 Men as risk

There is a prevailing cultural view that men pose a potential risk to children, particularly within childcare settings (Robb, 2010). This can present as an unspoken sense of unease as fathers in Doucet's study realised when they tried to take their turns in an informal baby-sitting circle (Doucet, 2000), and this is what I encountered on the wards. Fathers in Doucet's study described feeling like a "pervert" under female scrutiny in schools, nurseries and similar places (Doucet, 2006b).

Although no-one in the study openly expressed the view that men may pose a threat to children, there was a marked difference in the incidence of fathers staying overnight in the open bays compared with the cubicles.

"It's 7a.m One father was resident in an open bay last night. This was the first time I'd seen this- child had been admitted in early hours of the morning" (Observation notes 4)

"There's a father resident in an open bay- it is more common for fathers of children in cubicles to stay - is this because it's just that the fathers of younger children (who are more likely to be in cubicles anyway) stay more frequently than older children or because fathers feel more comfortable about staying in a single room rather than on the ward?" (Observation notes 16)

No participants in this study suggested that men were less welcome on the wards than mothers. Similarly Hughes (2007) found that parents' felt fathers were as welcome to stay on the ward as mothers; she notes though that no fathers

returned a questionnaire, so one wonders whether the 'parents' were in fact mothers.

Nonetheless, fathers may have felt uncomfortable staying with their child in an open bay. There were notices up forbidding the drawing of the curtains around the child and parent's bed at night. Managers reminded the nurses to enforce this rule. Thus there was little privacy at night for parents and children in the open bays. The perception of men as posing as a risk to children may have been a factor.

Whilst not directly addressing risk, Hobson and Noyes (2011) do identify the challenges and discomfort experienced by both male children's community nurses and fathers who need to perform personal care for chronically ill children. Within the Early Years field, Jones (2007) has begun to explore the topic of male primary teachers, finding that male teachers are kept under scrutiny by their female colleagues. Jones argues that discussion of men as risk to children is taboo within Early Years (Jones, 2007). It seems to be equally true within children's nursing. There is no specific discussion of men as risk within children's nursing literature. Any such discussion would need to include male nurses as well as fathers.

7.4 SUMMARY

In this chapter I have explored the cultural aspects of gender which influenced fathers' experiences, in particular the ways in which matters maternal were privileged. Gender is inevitably one of the ways in which aspects of embodiment effect relationships between parents and nurses. Yet, gender has been largely ignored in previous research with parents of children in hospital, but the critical realist approach to this study has revealed its importance as a generative mechanism in this setting.

I have shown how children's nurses and the hospital as an institution function in a gender-biased way.

Fathers could gain the impression that, regardless of their relationship with the child and role in the family, "the hospital" saw the role of the parent providing care

for the child in hospital and making decisions about the child's care as belonging to the mother.

Chapter 8 The domain of polity and economy- working and parenting

8.1 INTRODUCTION

This domain is concerned with the broader political and economic factors which have pervading influence over all the other domains (Houston, 2010). Work, meaning paid employment outside the home, and factors relating to work emerged from various aspects of the study and exerted a powerful influence on fathers' experiences.

Whilst the work: home interface has been explored by sociologists within the fields of family studies and gender studies, it has been argued that nurses in general have paid little attention to how men and women manage work and home (Hall and Callery, 2003). The notion that parents are also workers is largely absent from research in children's nursing, although Callery identified that fathers were more likely to continue working than mothers, unless they were required *to substitute* for mothers (Callery, 1997a). There has been considerable social change since Callery's research, so it is timely to address these issues in my study.

Discussion of the social policy context of parents as workers in the UK and the influence of various aspects of work on fathers' experiences are the focus of this chapter.

8.2 PARENTS WORK

As de Vaus (2009, p 118) has written:

"For most parents, life is no longer a matter of being a parent or a worker-it's both"

In modern families the roles of home-maker and breadwinner have gone; instead of being assumed because of gender, family roles are negotiated and shared (de Vaus 2009). Yet I showed in chapter 2 how the origins of parental involvement in care were based on the former model of parental roles.

The notions of "work- life balance" and "family friendly" working policies have become influential in policy initiatives in recent years, as discussed in Chapter 1. Coupled with increased female –and particularly mother- participation in paid work, and the involved fatherhood discourse, these have led to changing practices and expectations for employers and workers. O'Brien *et. al.* (2007) argue that governments and organisations across the world have been developing support for working fathers' caring responsibilities. These moves are strengthened in the U.K by the Gender Equality Duty which requires all public services to promote and take action to bring about gender equality (Local Government Improvement and Development, 2011) and the Equality Act 2010 which protects individuals from unfair treatment and promotes a fair and equal society (Government Equalities Office, 2010). My study therefore provided an opportunity to explore the effects these policy and legislative are having on real lives and practice.

Of the fathers I interviewed, all worked outside the home although two were on paternity leave at the time of their child's admission. Four fathers had partners who did not work outside the home at all and two had partners who were on maternity leave but intending to return to work. The other mothers all worked either part or full time. This pattern is broadly consistent with the national picture in the U.K of dual earning parenting as the norm, as discussed in chapter 2. Hospitalisation of a child for an acute illness and the expectation of twenty-four hour parental presence therefore presents a particular challenge to families.

Featherstone has argued that the role of main economic provider remains central to fathers' sense of their father identity, even with the increase of mothers working (Featherstone, 2003). In accordance with this, the majority of fathers I interviewed saw themselves as the family's main breadwinner, whether or not the mothers also

worked. One mother gave up her part-time work in order to stay with the child, without further thought.

"not realising that we've got another child who has to be sorted out and a day job. I mean thankfully Maria only had a part-time job so she was able to leave that but I mean the bulk of our money comes from my job. So I can't just turn round and say I'm taking two weeks off and I'm going to be in hospital 24 hours a day, you can't do that..," (Derek in Derek and Maria couple interview)

8.2.1 Juggling work and care

The greater part of research on balancing work and family responsibilities has focused on women (de Vaus, 2009). However within this study, some fathers continued to work, be responsible for well siblings, spend time with the sick child and support the mother.

" that's it, so dropped her off in the morning, left Phoebe at her friend's, with, at the hospital with Maria and Philip, and I ended up with going back to work, then at work and going back to the hospital again around 1700, 5 o'clock and so in the evening, and so it just went on like that for 6-7 days..." (Derek in Derek and Maria couple interview)

Fathers' capacity to juggle work and care depended in part on the degree of flexibility of their jobs. Barry was able to care for his son during the day throughout his stay in hospital even though his employer did not have time off, because the nature of his work meant he could work anywhere and at any time of day. Derek was also able to be flexible within some boundaries.

"D: Yeah For example, when Philip was in I could go in an hour later there was no fixed time when I went in and I could leave whenever I wanted, I could go at lunchtime and spend two hours there, but what basically, the way I feel, being a manager myself, as long as I've got the day job and everything was done, then no problem at all , going in later, staying later, going in early, everything else it was all there" (Derek in Derek and Maria, couple interview)

However he eventually needed to take time during his son's relatively prolonged hospital stay.

Although not related to ill children, McDonald and Ameida's investigation into fathers' work and family roles revealed that fathers' degree of decision-making latitude at work was a moderating factor for a negative association between long working hours and time spent with children (McDonald and Ameida, 2004). They suggest therefore that the nature of a father's job is a significant factor in the amount of time he spends with his children. This appears to be the case also for

fathers within my own inquiry. The fathers I interviewed may not have been typical. All appeared from our discussions to have some degree of autonomy in relation to their work commitments. Other fathers I spoke to on the wards gave working long hours or being too busy at work as reasons for not being able to be interviewed, so my interviewees may have been those who had more control over their work hours and commitments. Nonetheless, these fathers working long hours were present on the wards with their children at least some of the time. It is also true that some fathers were not there and it is not possible to in a study of this nature, in which participants are recruited from the ward to determine why that was; working hours may have been one factor among others. It would seem that fathers in jobs in which they have little discretion over working hours may be at greater risk of marginalisation.

Although Harry initially intended to juggle work, family and hospital commitments, he found the emotional strain such that he realised this pattern could not be sustained.

"Yeah, this was the point where I had to tell my work that I can't come in for a week at least, until this is all resolved. It's not just my wife that's affected; she needs my support but obviously I'm affected personally emotionally so .. yeah.. so.. yeah, that was the first time I took time off, just left work in the morning and went straight to the hospital" (Harry, father interview)

His situation led him to disclose his emotions at work for the first time.

"I mean the thing is my manager is also a parent. The way she came across is I said, look this is the situation, and I mean, I came in, I was .. under intense .. stress. And it's not... something... they'd never seen me..it's not something they've ever ..seen me ..ever professionally. And they've known me seven years, I've been there seven years so and that was the first time that I'd come into an office with... a.. an... emotional angle to me" (Harry, father interview)

Thus my findings demonstrate that the culture of father involvement has led to a situation where men are willing and able to share their concerns about their children at work and be supported by managers in doing so as a legitimate part of being a worker and a father.

8.2.2 Taking time off work

Six of the twelve fathers had time off work while their child was in hospital, another was on paternity leave, one was on annual leave when his child became ill and another's day-case admission was at the week-end. Therefore three continued to

work. Of these three, one, Barry, negotiated to work away from the office and Zack worked part-time and was not scheduled to work during his child's admission.

"B: And so that Friday she took a day off and I went to the office and talked to my boss and "This is the situation, he's just had a major operation and unfortunately, there was another project , and that needs immediate attention and that was even more... strict deadlines than the first one because that one... a client of ours was suing us if we didn't deliver on time..

I: Right

B: Cos even... And then my boss was saying " OK we'll come to an arrangement you can work away from the office but you need to be on the phone whenever we call you " And I said " Well that's not possible because you can't use you know" and he said " Well you can go outside and keep checking your calls" and so it was... that was the arrangement we came to so every fifteen minutes I would call up and check my messages and call them back. It was a joint team effort. [...]

*Yeah, what I used to do was er, basically, cos I had to do 7 or 8 hours, and that's the time I have to do but it was more job-based because I told my manager that "there's no point in doing 8 hours and just filling the time it's more- the work needs to be done and it can be done at night or morning. I[...], there's a certain piece of work that needs to be done, so I'll do it sort of 3-4 hours at night, you know, coming back in the evening ...and then waking up early. (*Barry and Ali, couple interview)

Of the fathers I interviewed, only one continued to work full- time throughout his child's stay, and even he had time off later during his child's recovery at home.

" I mean my management wanted to give me a week off so, but I said no I'll come to work because I didn't want to sit at home, I don't like just sitting at home. I like to, I'm a workaholic" (Eddie, father interview)

Of note here is that Eddie did not see himself as spending time in hospital with his son if he were to take time off, unlike the other fathers. Eddie's son was a teenager and an elder daughter took care of the other well child in the family. His wife was a nurse who took it for granted that she would stay with her son. As such he is different from the other fathers I interviewed, who had significantly younger children in hospital or others to care for. Eddie may have been enacting an older style of fatherhood or father involvement may change as a child grows up.

Of the six who had time off, one was self-employed so did not have to ask, but had to inform customers he would not be working. This resulted in loss of income for the family, yet he felt his priority was to provide practical and emotional support for his wife and child.

"J: Yeah, to suddenly cut your week down to a couple of days it does hit you, especially because I'm the only one- Sam doesn't work ..
I: so it has an impact then
J: yeah, it's my money we rely on, yes." (Jake, father interview)

The remaining five negotiated time off with their employers, sometimes juggling work and care.

*"I had to go back into work on the Wednesday and Thursday I think. So I needed to have a good night's sleep, get into work. And then on the days I went in to work I quickly went into the hospital first, then I left work and came back to the hospital so ... it was quite full on" (*Frank and Tara, couple interview)

Fathers therefore had leave on a discretionary basis, *yet* all but Barry's employer were amenable to this. A variety of arrangements were made with some fathers continuing to do some work but not to follow their normal working patterns.

"Yeah, they were fine. It's only a small family company that I work for and I've been there for about eight years now so they looked after me really well. What I did was take sick leave for the first two weeks, then took some holiday time after that and took some days that were owing to me in lieu after that. So when he came out of hospital I still had two weeks paternity leave. So I basically delayed it all until he came home." (Adam, father interview)

"D: Yeah For example, when Philip was in I could go in an hour later there was no fixed time when I went in and I could leave whenever I wanted, I could go at lunchtime and spend two hours there, but what basically, the way I feel, being a manager myself, as long as I've got the day job and everything was done, then no problem at all , going in later, staying later, going in early, everything else it was all there" (Derek and Maria, couple interview)

"F: Yeah, but work were really good..
I: were they?
F: yeah. ... At my work the compassionate leave is down to my line manager so she just said "take it all off if you want" but I didn't want to leave my team and there was difficulty with other stuff that was supposed to be going on so I did a bit of work." (Frank and Tara, couple interview)

"Oh absolutely no problem at all, I just said that ...can we just look at what the options are so that was absolutely fine so when I came back they decided that I wasn't going to have it as special leave so I've had to take it as flexitime so they've all been very reasonable but not quite the.. I've had to do it on flexitime." (Greg, father interview)

Fathers valued the flexible responses from their employers in relation to time off and it was evident that some found their managers in particular to be emotionally supportive too.

"D: My employers was extremely supportive, they were brilliant weren't they? (Name) was, cos I've actually just transferred roles, I've gone to a headquarters role rather than an area, when all this was going on with the hospital and in and out, the area role my governor (name) was very, very helpful, I could take time off at short notice, just do that, look after Daphne, work from home, I've got a laptop, wireless, so yes he was great. Then my current boss has said exactly the same so, if you've got any problems, phone him let him know and we'll support you ." (Derek and Maria, couple interview)

*I mean the thing is my manager is also a parent. The way she came across is I said, look this is the situation, and I mean, I came in, I was .. under intense .. stress. And it's not.. something.. they'd never seen me ..it's not something they've ever ..seen me ..**ever** professionally. And they've known me seven years, I've been there seven years so and that was the first time that I'd come into an office*

with.. a.. an..emotional angle to me. So it was.. yeah, so it was.. yeah basically I told her "this is what's happened and I think I need to be there to support my family, can I have next week off? " and she was ok, the first thing she said was "I'm a parent I know what's happened. I can appreciate what's going on. ***Of course*** *you can, yeah. Just go, you know what I mean* (Harry, father interview).

"There was not any 'Oh we need this or can you just tell us about that'. They just left me to it and that was exactly what I wanted them to do so . You know I just reported in a couple of times and they were all... quite keen to know how she was getting on so it was quite nice (Greg, father interview)

Fathers' reports of supportive responses from employers contrast with experiences of mothers reported elsewhere. Backett-Millburn *et al.* (2001) found that mothers found it difficult to take time off to care for a sick child and feared that they would be seen as unreliable employees if they did so. Perhaps employers saw these fathers as the heroes that nurses described (discussed in section 7.2.1).

Nurses perceived that it would be easier for mothers to get time off work to be in hospital with their child than it would be for fathers.

"It's probably easier to get time off work if you're ... just because you're a mum rather than a dad" (Tracey, nurse interview)

I found that this was not the case. Barry's wife – a teacher was refused permission to take any time off, although through persistence and her union's support she gained one day's absence from work during her son's fourteen day admission. Her anger about this was evident in the interview. This couple managed to maintain parental presence in hospital through doing shifts, with the mother staying on the ward at night and working during the day, and the father working on the ward when he could and late into the evening at home. Eddie's wife was a nurse and although she was able to stay in hospital with their son, her employer made it clear that she had to make up those hours at a later date.

It is notable that both the mothers in my study who had difficulty worked in the public sector. It raises the question for me as to whether this is coincidence or whether public sector employers are less supportive of parents than those in the private sector. Given that a greater proportion of the public sector force is female, this may be significant for a large number of women.

Under current legislation, each parent has a statutory entitlement to unpaid parental leave of up to 13 weeks from birth to the child's fifth birthday; normally a 21 day notice period is required though individual employers can waive this (www.direct.gov., undated). The guidance specifically states that it can be used to spend time with the child in hospital (www.direct.gov., undated). None of the families in this study made use of parental leave, although they were aware of their entitlement, because the leave is unpaid.

"In the fact of the leave I had I just used – offered to use annual holidays because I had such a huge amount so there was no issue about that – it's unpaid parental leave in our office and i don't know any father who could, I couldn't afford to take unpaid parental leave, it's just a waste of time to be honest. I'm like everyone else you know, my mortgage and my outgoings are based on my full 100% income. I can't afford (laughs) I can't afford unpaid leave for one week to be honest you know. " (Harry, father interview)

"Yah I know you can take some time doing that but I didn't want to lose the money because while Sarah wasn't working, we just can't afford to lose that time so er. .we didn't want to do that. And I do have a decent amount of holiday time anyway so it wasn't really an issue.." (Greg, father interview)

Whilst families may not have used official parental leave, the legislation could still be influential. It could be contributing to a workplace culture in which it is acceptable for fathers to take time off to meet their caring responsibilities.

One nurse was aware of the availability of parental leave and presumed that this was one of the reasons for increased father presence on the wards.

"There's a law now that fathers can get paternal leave can't they? So now that employers are obligated to give time off if a child is sick in hospital, I think fathers are getting it so it might be associated with that" (Val, nurse interview)

Generally nurses showed minimal awareness of how work commitments might affect parents' experiences, reflecting a wider lack of concern, knowledge and understanding about parents' lives and commitments beyond the walls of the unit. The use by men of work as a refuge from the strains of having a chronically ill child has been found by others (Chesler and Parry, 2001). The extent to which it is a coping strategy for fathers with acutely ill children is unknown. There was a suggestion from one father in my study that he returned to work after a period of staying with his son because he needed to get away from the emotional strain, so it is not possible to determine whether this is common paternal response.

"F: We were out of the woods with him

I: he was over the scary bit?

F: over the scary bit yeah, so actually I found it .. I needed to have a break." (Frank and Tara, couple interview)

8.3 WORK AND MASCULINE IDENTITY

Work has long been seen as central to masculine identity and an essential aspect of the father role in terms of providing for his family. As Yarwood argues,

"being economically active within the labour market remains linked to the conception of good fathering in the UK" (Yarwood, 2011 p150).

All the fathers I interviewed spontaneously mentioned their work during the course of the interview. In doing so, I interpreted that they were establishing to me their identities as working men and providers for their families, in addition to their position as caring fathers. One father chose to be interviewed at his workplace, showing he had the authority to invite me there and choose where the interview took place within the building – the boardroom! Thus the fathers in the study held masculine ideologies which showed continuity with historical masculine ideologies but which they were re-shaping to incorporate their caring responsibilities.

They did not appear to perceive a conflict between the two roles of carer and economic provider, rather providing was part of their caring. Whilst economic security was important to them, they were keen to stress that if there were to be a contest between work and family, it would always be "family first".

"My objective in life is to, now at this time is to support the family and that's all that I want – that's my ambition out of life to make sure my family is comfortable. Anything outside of that is a bonus- I don't look to get anything, like career ambitions you know, and er, whatever it is, you know, er, getting a bigger house and things like that. Those are just things that you, I see as a bonus so my needs um, they.. don't really.. come.. into factor when there's such a serious situation affecting my family." (Harry, father interview)

In taking time off to support their families, fathers showed their commitment to the caring aspect of fatherhood and that this was a comfortable part of their own masculinity. In feeling that this was an aspect they could and should express in their work context, without diminishing their standing as men and as employees, they were responding to a culture in which involved fatherhood is encouraged, whilst

also through their actions reshaping fatherhood at work. This is an illustration of Bhaskar's Transformational Model of Social Activity, shown in figure 3.2 (Bhaskar, 1989).

One father I had a long conversation with on the ward suggested that fathers' status at work could impede their communication with staff on the ward. His comment highlights the importance of hospital staff not making assumptions but also the importance that status and a fear of loss of face may have for some men.

"He stressed the importance of not being afraid to ask stupid questions- gave the example of a father he'd been in another hospital with who was "very high up in his company" who was reluctant to ask the simple questions because he thought it was beneath him or that he should know that" (Observation notes 39)

8.4 UNDERSTANDING NURSING AS WORK AND NURSING AS WORKERS

Doucet (2006b) has argued that fathers may have difficulty fitting in what she terms "estrogen -filled worlds", a term which I think could be applied to the wards I studied. I found that some fathers used the world of work to frame their understanding of the social world of the wards. Harry suspected that this was different to how mothers perceive the ward situation.

*"I don't think, I don't think it's a working environment as far as a mother's concerned. They're there on an emotional basis, no professional capacity whatsoever" (*Harry, father interview)

In interviews, fathers showed how they regarded nurses as workers, rather than carers, making some insightful observations. In these comments they revealed how they applied their own occupational knowledge to nursing, but also how this knowledge could influence their own behaviour.

*"D: I mean training wise, cos I've done a lot of training and stuff like that within the industry that I'm in and when I was in the police so I did a bit of training and stuff like that. There seems to be a tendency of you know you've got the male attitude, you've got the female attitude, you know we deal with males in this respect and we deal with females in that way." (*Derek and Maria couple interview*)*

"D: You know when you're looking at competencies and stuff like that you've got your unconscious competents haven't you and they do it, they know they're competent and they just do it. Or your ones that are conscious competents, when they've got to think about it, they know they can do it but they've got to go through the stages so it's like get the arm, get the cannula, put the tube in, give the drug thank you very much and away. They know how to do it but they don't think about the little bit in between where yeah, I've got to do this and I've got a six year old child who's going to be in tears,

floods of tears, I'll do that bit but I'll calm you down next bit. You know so you've got the two stages of competence where you've got the unconscious and conscious competents and the conscious competents are thinking about it and that tends to a lot of the younger nurses, the newer nurses they're at stages where they've got to do that". (Derek and Maria, couple interview)

*"F: There were definitely some that were just more attentive and better than others.., so I would say to them, look to those people and look at how they deal with it and then have a look.. I mean in my industry, we do a lot of presentations, for the big offices we film a lot and it's only when you watch yourself, you learn, so if there's any way they can watch themselves, then compare themselves to how someone else does it , who's like a parent or something, then I think they'd learn a lot about.. just the little subtle things about how you deal with them." (*Frank and Tara, couple interview)

"F: Cos it must be a really tough job.. if..to them, I thought they were brilliant. You know cos we were pains in the neck really.. we were worried and we were bugging them constantly ..

I: What makes you say you were pains in the neck?

*F: Cos if I'm at work and someone's constantly bugging me and asking me stuff it annoys me so I just put that onto them really (*Frank and Tara, couple interview)

Some also applied organisational knowledge from their own working lives to the ward environment and their experiences. Derek's frustration arose because his child was under the care of two separate teams of doctors who functioned independently and, not being privy to, or perhaps not subscribing to the particularities of hospital consultants and their position within the hospital culture, he could not understand why someone did not make them speak to one another.

*D: Yeah they weren't talking. See I work in the railway industry and I mean, we do have the issues of not talking to one another [...]: But my role is that I do, my role what I do now and what I did then I attempted to speak to other departments and other functions and if there's someone that was my equivalent and if I was dealing with something then I would at least attempt to phone them up and say "Oh look by the way I'm doing this. If you don't like my decision tell me now and I'll change it or we'll look at doing something else. If I don't get a reply from you because you're being an obstinate ****, then I'll just carry on and do it" But then you go into this hospital where you've got these people making these decisions and one's making one decision and not talking to that hand there, and then that hand there is 8 or 9 hours later is, and then it all starts again the next day and it just rolls on and rolls on and rolls ones". (*Derek and Maria, couple interview*)*

*"On personal experience going to a professional environment in **any** professional capacity, sometimes when I'm on the phone with a client who complains about something, and **I've** identified because I've had the same kind of complaint and I say, you know what I mean ' I know exactly where you're coming from' and I.. I think that makes them feel that I'm a much more approachable person, you know what I mean*?" (Harry, father interview)

These comments also demonstrate how children's nurses are under constant parental scrutiny. Although there were a few exceptions, overall, fathers expressed admiration and respect for *nurses'* knowledge and professionalism.

"But...we couldn't have really asked for any more from the staff from their professional side of things they're obviously all very capable at what they do and cool and calm under pressure, certainly at the start it was (staff nurse name) who ran in on that first night so we thought about that the

*whole time we were there. It was sort of- she'd saved him. Yeah you got that instant respect for people and just because it was her that was there it didn't matter. It could have been any of them so you just feel like you're in a really.. **safe place**".*(Adam, father interview) (emphasis original)

"I thought the ward was brilliant, I thought you know the nurses were brilliant. I wouldn't say much for the consultants, you know they have so many people to see and they just breeze in and out but the nurses stick it together. The nurses were brilliant." (Frank and Tara, couple interview)

"I mean generally, the general perception is that they were all very professional and you know had a job to do and were just nice people" (Ivor, father interview)

8.5 SUMMARY

In this chapter I have shown how work and being a breadwinner remains a central part of fathering for many fathers. Fathers attempted to manage the conflicting demands of work and having a sick child in hospital. Although my observation periods were spread across the twenty-four hour day and seven day cycle, I tended to visit more frequently in the evenings and at weekends as there were likely to more fathers there at those times, although father presence was not *restricted* to these times. I have shown that for several fathers, it was not possible to continue to be effective at work whilst their child was ill.

The constraints around official parental leave mean that, although well-intentioned, it is not fit for purpose for parents responding to the circumstances of having an acutely ill child. However it may be positively influencing workplace culture to make it more acceptable for fathers *and* mothers to take time off because their child is ill.

Fathers appear to approach the children's ward in a different way to mothers- interpreting their own observations and experiences through their knowledge of the world of work and applying this knowledge in their appraisal of nurses.

9.1 INTRODUCTION

I began this study with the impression that fathers were taking a more active role in the care of their children than in the past and than is represented in the children's nursing professional and academic literature. I thought from my own personal observations and professional experience as a children's nurse that this more active role carried through to when their child was acutely ill.

I have shown in chapter 1 how the early 21st century father expects and is expected to be actively involved with his children's lives. Lewis and Lamb (2007) argue that professionals and academics do not acknowledge the complexities of fathers' roles in families. Although there is a significant body of research on fathers and on fathers of children with chronic illness, they have largely been overlooked in relation to children in hospital with acute illness.

My findings provide some evidence to support the impression that fathers are active carers of their sick children in hospital and their involvement extends beyond direct care, whilst I acknowledge that it is not possible to be definitive as numerical data on which parent is present and involved in care is not available. Nurses in this study reported that in their experience too, more fathers were present on the wards than has been the case in the past. Nonetheless, it appears that from nurses' perspectives, paternal presence and involvement in care appears optional whereas for mothers it is obligatory.

In this chapter I consider the extent to which I have answered my research questions highlight key findings and present again a model of the father's role in hospital and the factors which influence it. I consider my findings in relation to the three dimensions of fatherhood identified earlier, protecting, providing and participating. I also reflect on research design and methods, evaluate the efficacy of my research strategy including strengths and the limitations of my study and my

own role during the research process. I also identify the implications which arise from my findings for practice, policy nurse education and future research.

9.2 RETURNING TO THE RESEARCH QUESTIONS

The dominance of mothers' perspectives in research on the experiences of parents in hospital was demonstrated in the literature review. I have shown how the movement to support parental presence with children in hospital had its origins in attachment theory and was concerned in the first instance with mothers. Early literature focused on mothers being resident with children and some time during the 1980s nurses began speaking of "parents" being present, whist still in fact meaning mothers. Previous work, in focusing on resident parents' experiences, has in consequence focussed almost entirely on mothers (for example Darbyshire, 1994; Callery 1995; Coyne 2003), meaning that the contributions of non-resident parents, usually fathers, has been unrecognised and under-researched. So, whilst there is a body of research on fathers with chronic illness and a developing scholarship on fathers in neonatal units, mostly originating from outside the United Kingdom, there is very little evidence to inform nursing practice with fathers on children's wards.

I have also argued that "involved fathering" is becoming a social norm and is seen as highly desirable in public policy. Whilst guidance on working with fathers exists for midwives (for example Davies, undated) and early years practitioners (for example Sanders *et. al.*, undated) there is none for children's nurses.

Thus, the questions I developed were intended to begin to address the need for an evidence base for children's nursing practice with the fathers of acutely ill children in hospital:

What do fathers do during their child's stay in hospital and what determines this?

What determines their level of involvement in care and decision-making, how and why?

How do nurses and fathers relate to and understand one another?

How are partnerships between fathers and nurses constructed and expressed?

In answering these questions, what fathers do is encapsulated in the three dimensions of fatherhood I have identified: protecting, providing and participating. Key insights from findings from across the domains of social life in relation to each of these are highlighted below. Figure I.1, which demonstrates the relationship between the different elements of my findings, is presented again here (p 242) for clarity and convenience. The second, third and fourth questions are addressed by my findings on father-nurse relationships. My study also led to three other key insights which I consider important to achieving an understanding of fathers' experiences, even though they do not address my research questions. These are: the significance of embodiment; the importance of work and having regard for the whole family.

Nursing practice with parents appeared still to be predicated on assumptions of a heterosexual nuclear family with non-working mother, working father. These may have been valid when the concepts of parental presence and involvement developed but no longer reflect the diversity of roles, relationships and structures in families in the United Kingdom. Whilst fathers were often seen as marginal to the child's admission, in fact they were integral to the family's experience of the illness and stay in hospital. In my study, the focus on fathers, whether they were the resident parent or not, has revealed both the varied roles that fathers may adopt and the importance of the non-resident parent to what happens inside the hospital.

9.3 PROTECTING

I have shown that fathers experience an emotional need to be physically present with a sick child, in a similar way to that which has been described for mothers (Darbyshire, 1994; Coyne, 2003). Strong protective feelings have been identified among fathers of chronically ill children, relating to paternal identity (McNeil, 2007), and there was a protective element in this study to fathers' need for physical presence with their children, particularly during painful procedures. In meeting this

need though, fathers experience significant challenges arising from: their own circumstances and responsibilities (such as work and caring for other children); their relationship with the child's mother and the mother's attitude to childcare responsibilities; the imperative that one parent can stay overnight as a result of lack of space; nurses' assumptions and an institutional gender bias.

Fathers' need to be strong during the child's hospital stay has been identified elsewhere (McNeill, 2007; Colville *et. al.* 2008) and can also be seen as protective in function. Fathers in this study consciously role modelled coping to support the child and mother's coping, they managed their own emotions and thoughts and influenced mothers' thoughts. Optimism and keeping positive have been shown to be coping strategies of fathers of children with chronic illness (McNeill, 2007). Such approaches may be important aspects of how a family copes in the short, medium and long term. However fathers appearing in control emotionally could lead nurses to assume that fathers did not need emotional support, particularly in the context of the relatively superficial and short-term relationships between fathers and nurses on a general children's ward.

Fathers' protective behaviour and talk extended to the mothers of their children; for example, both resident and non-resident fathers tried to get decisions made or to obtain support for the child's mother. Fathers' protective actions were reminiscent of Chesler and Parry's findings that part of everyday fathering is that fathers "fix things" and this carried forward into their role as fathers of children with cancer (Chesler and Parry, 2001). Within my study fathers' actions in seeking to "fix things" could cause tension between fathers and nurses. Fathers also monitored nurses' behaviour and particularly valued nurses' supportive behaviour towards the children's mothers. This protective attitude towards mothers contrasted with the way some mothers spoke of fathers in disparaging terms *("he goes home and watches the football"),* although this difference may be a consequence of gender disparity and similarity between me and the participants.

Some fathers also exhibited protective behaviours towards mothers in interviews- for example, in their choice of interview location (away from the family home,

thereby protecting family privacy), in discussing their partner's need for care from the staff, or by lowering their voice when discussing traumatic experiences in order to protect a mother listening in another room.

9.4 PROVIDING

Providing, in a narrow meaning of breadwinning, is traditionally thought of as a key aspect of the father role. Many of the fathers' actions during the study were related to providing in a broader sense, including: working to provide family income, their provision of care for well siblings and their provision of supplies such as food and clean clothes for the child and resident mother, which I frequently observed. Fathers frequently juggled these various aspects of providing simultaneously at a cost of considerable stress, in addition to their concern for the sick child.

For some families, maternal income appeared discretionary so that a mother was able to cease working to accompany the child because the father continued to work. Some fathers gave accounts of taking time off work themselves in order to better support the child and resident mother. I was struck by the fact that even non-resident fathers who did not have responsibility for caring for well siblings took time off work to support mothers and be with the child in hospital. It is a powerful indicator of the extent of social change, in relation to couple relationships, gender roles and involved fathering. This represents a significant change in attitudes towards responsibilities for children and also relationships between mothers and fathers as couples, from the time when a mother could prioritise cooking her husband's meal over staying with her child and gain support from a paediatrician in doing so (see Meadow, 1964).

I had not realised at the start of the study how significant work was and I did not have a research question relating to work or employment status. It became apparent from some fathers what their specific occupation was – for example, in one home I stepped over copper pipes and boxes of copper fittings in a hallway to conduct an interview with a plumber. However I did not ask fathers about their

employment status or specific occupation as part of the demographic data I collected. I was anxious to be inclusive and did not want fathers to think I was making judgements about class. I had not realised at the start of the study how significant work was. That was, with hindsight, an error of judgement.

If more nurses have awareness of parental entitlements to leave, they could use their knowledge to empower parents to request leave, thus at least in part, reducing the pressure on families.

Very often, fathers' roles as providers in more general terms- providers of care for siblings and for the sick child, providers of essential supplies, and providers of emotional support to mothers- were critical in enabling mothers to be present with the child in hospital. Yet these paternal contributions to the care of the child and to family well-being were largely unrecognised by nurses, who seemed to regard a non-resident father as not involved or interested.

The importance of aspects of fathers' providing role to the ill child's care has received little attention from other researchers. It has become evident in this study because of the focus on fathers, whether or not a father was resident with the child.

9.5 PARTICIPATING

Parental participation in care and decision-making is central to children's nursing practice. My study has shown fathers to be active participants in the care of their children in hospital, as they have been shown to be in relation to chronically ill children, although they are at times treated as secondary carers by health professionals (Swallow *et. al.,* 2011).

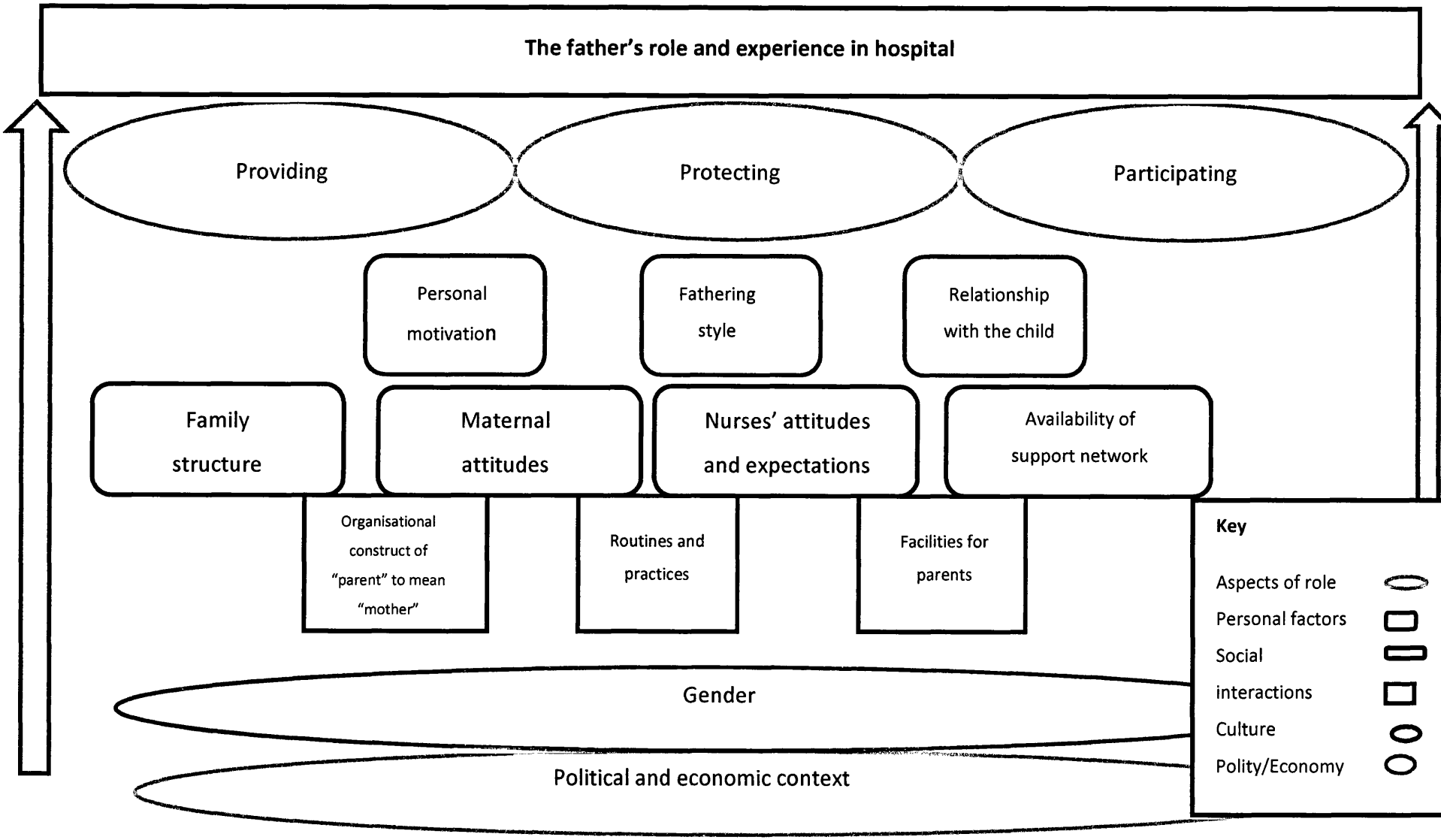
Nurses have been shown elsewhere to consider that mothers are better carers of sick children than fathers (Hughes, 2007). In this study, whilst nurses clearly expected fathers to participate in care, this was as substitutes for mothers in their absence. It also seemed that fathers' competence as carers had to be demonstrated to nurses *and* mothers, whereas mothers' competence as carers was assumed.

Parental contributions to care were essential to the functioning of the unit and were assumed by nurses as other researchers have identified (Darbyshire, 1994; Callery, 1997c; Coyne, 2007). Mothers, fathers and nurses shared a view that fathers should do their share of this work, reflecting the societal trend for greater parental involvement in childcare (Lewis and Lamb, 2007). My study has shown that fathers undertook the same range of routine childcare activities as mothers, including when mothers were present, so their participation in care extended beyond being mother substitutes. However, relationships between fathers and nurses could not be construed as equal partnerships. Parents were positioned by institutional practices as subordinate workers who were dependent on nurses.

Throughout this study, I have deliberately used the term 'routine childcare' for everyday caring activities for children, such as meeting hygiene and nutrition needs and providing comfort and reassurance. Yet elsewhere, others, (for example Coyne, 2003) use terms such as "basic mothering tasks". In itself this language excludes fathers from these activities and displays the bias towards the maternal that I have argued children's nurses frequently and unconsciously exhibit.

Fathers' participation in decision-making was hampered by nurses' and sometimes their own perceptions of mothers as the authority *on* their child, as also found by Högland and Holmstrom (2008) and also the authority *for* the child. So whilst a mother could make autonomous decisions, nurses imagined fathers would need to check with mothers first. Institutional routines such as the timing of ward rounds and the perception of fathers' engagement in these as optional served to reduce the scope for fathers' access to and therefore involvement in these key decision-making events.

Figure I.1 Influences on fathers' roles and experiences during their child's hospitalisation



9.6 NURSE –FATHER RELATIONSHIPS

9.6.1 Gendered relationships

Nurses expected fathers to conform to unspoken norms: to support mothers, to be concerned for their children but not overly anxious, to be competent carers for their children, to comply with aspects of treatment and not to challenge practices or ask too many questions. Despite the considerable body of scholarship on fathers, nurses worked with fathers based on their own instincts and experience, just as I had done at the beginning of my career.

Doucet (2006b) has written of men's unease in what can be perceived to feminised places (or in her words 'estrogen filled worlds'). The wards in this study could be considered as such- it was evident that resident parents were expected to be mothers, and the nursing staff was almost entirely female.

Fathers in the study used their knowledge of the social world of the workplace as a frame of reference by which to understand their environment; to understand nursing as work and understand nurses as workers. It seemed to me that this enabled them to relate to what could be construed as a feminine environment and may have enabled them to feel less 'out of place' or enabled them to cope with this feeling. Fathers had considerable insights to share from this perspective. Whether mothers also regard the ward environment in this way is not known.

9.6.2 Negotiation and partnership

There is a significant discrepancy in the nature of nurse-parent relationships as they appear in children's nursing textbooks and in practice on an acute general children's ward. In reality, for the majority, nurses' relationships with mothers and fathers were generally relatively superficial and of brief duration, the nurse regarding the parent as a provider of routine childcare and the parent's contact with the nurse being largely restricted to contact during technical care episodes, such as monitoring of the child's condition or intravenous drug administration. In common with other research, (such as Hughes, 2007) parents perceived nurses as

perpetually busy and therefore felt obliged to carry out normal child care tasks, but they also *wanted* to do so.

The significant discrepancy between nurses' and fathers' views of whether they negotiated roles warrants further exploration. Other researchers have also found that nurses do not negotiate the extent of parental involvement in care (Coyne and Cowley, 2007). This begs the question as to why they continue to state that they do. The nurses in this study seemed to understand negotiation as setting out what was to happen and what actions were planned, whilst confirming that parents would perform routine childcare tasks. Nurses would ask a question such as "are you ok to carry on with your child's feeds, care and so on?" and consider this negotiation.

A constant finding from research is that more experienced nurses negotiate more than less experienced nurses (Casey, 1995; Kawik, 1996), as was the case in this study. One nurse I interviewed claimed negotiation was something one had to learn through experience. If this is the case, and children's nursing continues to claim partnership and negotiation with parents as central aspects of practice, this raises issues for children's initial and post- qualifying nurse education and how nurses are equipped with the skills to negotiate.

More experienced nurses may have greater confidence in their own situation and capabilities, or have greater status within the ward, and therefore have a lesser need to retain control. Alternatively, negotiation may just have to be learnt through doing, which has implications for children's nurse education.

The short lengths of stay of the majority of children after an unplanned hospital admission and shift patterns involving fewer but longer working days for nurses, combined to limit the potential to develop genuine partnerships with either mothers or fathers.

One might question whether, in some circumstances, it is really feasible for negotiation to take place at all. Even if nurses have the skills and attitudes to do this, parents come to the encounter in an unfamiliar environment, without training

in negotiation, at a time of greatly increased psychological vulnerability and anxiety, distracted by an overwhelming concern for their child. Perhaps the persistent absence of evidence for real negotiation between parents and nurses reflects this reality- at least at the time of the child's admission.

9.6.3 Professional education and socialisation

I offer two explanations of nurses' focus on mothers. Children's nurses are taught about attachment theory and the influences of Bowlby's early work on the care of children in hospital, which were discussed in chapter 2. Whilst current understanding of attachment theory acknowledges that the young child develops multiple attachments (Daniel and Taylor, 2001), it may be that historical accounts of developments in care for hospitalised children in children's nursing education have served to emphasise the mother- child relationship at the expense of attention to father-child relationships.

Within nursing practice, as nurses are socialised into the profession, they learn accepted and expected attitudes (Harper *et. al.*, 2008). I have shown in chapter 3 how historically, mothers have been the focus of children's nursing literature and practice. I have also shown how a need to conform to group norms operated. Therefore nurses coming in to the working environment learn the ways to respond to parents from those already in practice, thus perpetuating patterns of behaviour. As a consequence, the culture of the wards may have become somewhat fixed, not responsive to social change in the wider world. Thus there may be a professional zeitgeist prevailing which no longer matches the reality of families in society or children's nurses' own lives.

9.7 EMBODIMENT

Embodiment was important to a number of aspects of this study, but has not been reported elsewhere in relation to either mothers or fathers in hospital. Whilst the psycho-social experiences of parents have been considered in earlier research, discussed in chapter 2, in general physical aspects of their experiences have been overlooked.

Fathers have a physical relationship with their children as well as an emotional one and this was evident throughout the study in fathers' talk of 'flesh and blood' and of touch and in their seeking physical closeness and contact with their children which I observed. Yet embodied relationships with children are more traditionally attributed to the mother-child relationship (Doucet, 2009), as indeed they were in this study by both fathers and nurses, most commonly in relation to breastfeeding.

Nevertheless, it is worth considering Wolff *et. al.'s* finding about the importance of some aspects of male physicality – such as size, strength, depth of voice, are to some children (Wolff *et. al.*, 2010), it would seem important for nurses to recognise this, as paternal presence, for example during painful procedures, may be preferred by children.

Relationships between parents and nurses and nurses and children are also embodied. Fathers watched how nurses touched their children and formed judgements about nurses based on their observations. I saw no touch between fathers and nurses and I observed only a little touch between nurses and mothers. Again, this may relate to gender.

Fathers also talked of the influence on their experiences of physical effects of their child's stay in hospital such as being tired, lacking sleep and difficulties getting food. Of course these issues apply equally to mothers, but whilst nurses showed some understanding of maternal physical needs (for example in relation to breast-feeding), this was not the case for fathers.

On an institutional level, little attention had been paid to the physical needs of parents in general and fathers in particular. There were for example no shaver points and no separate sex bathroom facilities for parents.

One aspect of embodiment, which I think is a taboo, was the notion of men as risk to children, relating to perceptions of male sexuality. Although unspoken, this was nonetheless an influence on fathers' experience – reducing the number of fathers staying with children on the open wards and possibly limiting the contact between nurses and fathers of children in cubicles.

9.8 THE IMPORTANCE OF GENDER

My research has demonstrated how important gender was in shaping fathers' experiences. Gender frames individuals' perceptions of one another, consciously or otherwise, so it is always present in any interaction. Gender ideologies governed nurses' and fathers expectations of themselves and one another. Nurses and the wards as an institution operated a gender bias in practice which prioritised the maternal, so for example, mothers were seen as the natural carers of children. Within families, mothers also exerted the power which arose from gender ideologies relating to the maternal body to so that for example, fathers saw the mother-child bond as inviolable.

The fathers in this study clearly subscribed to an involved, nurturing style of fathering, although the extent of involvement varied. They felt comfortable to discuss their caring responsibilities in their workplace, suggesting that they did not feel that this would diminish their masculine identity among their colleagues. Thus my research provides further evidence that masculinity is changing.

My research shows that gender operated as a generative mechanism at the personal, social, institutional and cultural levels, in this instance to marginalise and sometimes disempower men. Fathers were disadvantaged by gender mechanisms within the wards. Gender also influenced data collection –see section 9.13 below. Yet discussion of gender has been absent from previous children's nursing research.

9.9 HAVING REGARD TO THE WHOLE FAMILY

The wide-reaching disruptive effects on family members of an unplanned admission of a child to hospital are demonstrated by the study, as a consequence of conducting interviews away from the ward and not just with the parent who had stayed in hospital with the child. It was evident that the child's admission caused ripples of disruption, spreading beyond the parents to siblings, aunts, uncles, grandparents and informal kin. Wider family members contributed significantly to supporting parents. This is a topic which warrants further investigation.

There is also evidence of complementarity in couples' decision-making and roles. Parents could be seen as playing to their strengths. Between them, different information- seeking behaviours met couples' needs. The notion of complementarity in couples has been identified in relation to parenting a child cancer and with chronic illness (McGrath and Chesler, 2004; McNeill, 2007). It would seem to be an important concept which could inform children's nurses understanding of families and practice of family centred care and enable them to progress from a view of fathers beyond that of mother substitutes. Nurses who had an understanding of complementarity could support parents through discussions at or around admission about their individual strengths, prompting parents to make decisions which enhance their team working and therefore supporting them to cope better with the experience.

9.10 INSTITUTIONAL PRESSURES TO CONFORM

Both parents and nurses experienced an institutional pressure to conform. Nurses responded to parents, whether fathers or mothers, who did not comply with nurses' expectations with disapproval, stereotyping and labelling, consistent with the findings of Coyne (2007).

Nurses themselves were also influenced by a powerful social pressure within the ward to enforce rules and conform to the norms in the ways they responded to parents. During one observation period, I was struck by the difference in practice of one nurse on duty that day. Unlike other staff, she did not adopt the "inform and leave" approach. She spent considerable time with both parents after the child was admitted and came back regularly to check that parents were au fait with what was happening and anticipated their needs for the child, in contrast to other staff who responded reactively to parental requests. She normally worked in another part of the children's service and was helping out as a one off that day. Therefore she was unaware of normal ward practices and unaffected by the pressure to conform.

I think this pressure to conform is a generative mechanism maintaining practice in a fixed state. Hence it explains how nurses could be practising with fathers on the

wards in a way that does not reflect the diversity of family roles and family structures the nurses' experience in life away from the wards.

9.11 EVALUATION OF RESEARCH STRATEGY

9.11.1 Critical realist ethnography

Adopting critical realism at an early stage as the underpinning philosophical position was an important decision which shaped the entire project. I wanted to know *why* fathers experienced their child's care as they did, not just *what* they experienced and *how* they interpreted it, with a view to improved practice in future. Hence critical realism was appropriate because of the emphasis in understanding generative mechanisms which have the potential to influence events.

Examining the experiences of the two fathers who did feel like partners, unlike the others in the study, and seeking to explain their different experience, revealed that nurses' maternal bias was a mechanism which could influence fathers' experience, but that this bias was activated by maternal presence. When nurses had no contact with a mother they were able to work effectively with fathers, when they had contact with mothers, fathers were seen as mother substitutes.

Bhaskar's TMSA (figure 3.1) (Bhaskar, 1989) explains how fatherhood can be both a continuing and changing social phenomenon. The critical realist recognition of the significance of individual agency within a social context sees individuals as able to shape their own performance of fatherhood. This creates the diversity of fatherhoods that are practised today and acknowledges the contribution of personal factors such as motivation and personality.

Critical realist ethnography enabled me to explore and accept the personal meanings and interpretations of participants as real while acknowledging that these cannot be fully understood without reference to wider structural issues in society. Hence fathers' experiences on children's wards cannot be fully understood without reference to changing family roles and the position of men as workers, nor the pervasive effects of gender on nurses, mothers and fathers. Thus the

experiences of fathers, children, mothers and families discussed in this thesis are located within a specific social context in the UK at present and this broader understanding and context has been reflected in my discussion, unlike in other studies of parents' experiences.

As a nurse educator completing a doctorate in Nursing Science, I wanted to capture the realities of nursing practice. Ethnography was chosen for the project because it is seen as a way of accessing beliefs and practices in context and also can yield understanding of the organisation of healthcare (Savage, 2000; Moore and Savage, 2002) and because it captures data which cannot be obtained through other means (Carnevale *et. al.,* 2008).

My intention at the start of the project was to seek an understanding of fathers' and nurses' experiences during children's unplanned admissions. Therefore I was not conducting an ethnographic study of being a children's nurse nor of being a resident parent, but exploring the interface between these two social positions. This focus was more challenging to maintain than I had anticipated, although decisions such as not working full shifts, not going on meal breaks with staff nor taking responsibility for patients made it easier. However these decisions also limited access to certain data; for example I was not in a position to observe whether, and if so, how, relationships between parents and nurses developed over the course of a thirteen and half hour shift.

At the end of the project I feel ethnography was the right choice of approach. It is compatible with critical realism. It gave me the flexibility to follow the data. Participant observation was crucial to the understanding I achieved. So, for example, I had not anticipated the significance of the corridor as a liminal place and the admission interview as a symbol of admission. Yet once I had become aware of this, I was able to centre my observations of nurses, parents and children there to see whether there was consistency in this finding. No other research approach would have revealed this.

However, ethnography is time consuming and its success rests on the effectiveness of the researcher as instrument. Fitting participant observation around a full-time

job was challenging and tiring. Observation is always partial and my efficacy as an observer varied, depending on the other demands on my attention at any given time. At times during the observation phase, when I reviewed my notes I realised that I had captured little that was meaningful that day.

The critical realist interest in a social structure that lies behind individual consciousness and intention (Alvesson and Skölberg, 2009) means that knowledge and theory from many fields of social science were used in the abductive analysis of the ethnographic data generated. This has also been time consuming, challenging and subject to the personal biases and blind spots of the researcher. A question that arises is therefore, if social structure is beyond participants' conscious knowing in everyday life, to what extent can the researcher claim their interpretation represents reality? What privileged access does the researcher have to enable them to identify this hidden reality (Alvesson and Skölberg, 2009)? Yet if one does not go beyond what is immediately evident, one is confined to the world of the empirical; critical realism challenges researchers to undertake theoretical analysis. Through such efforts, one *can* know and objectify social structures.

Critical realists make modest claims. Critical realism focuses on the possibility of causal explanations within the social world rather than certain cause and effect with the recognition that knowledge is transitive (Alvesson and Skölberg, 2009). Hence in the interpretation of fathers' experiences presented in this thesis, I have argued for example that gender could act as powerful mechanism to influence fathers' experience, shown how gender could operate in each of the domains of social life and provided the evidence on which this interpretation is made, and also shown how participants were enacting their own genders. It is fully compatible with a critical realist view to recognise that there may be alternative accounts and other generative mechanisms than those explored here may also have been operant to produce the actual events discussed in this thesis.

9.11.2 Houston's domains

When I first read both Houston (2010) and Layder (2006), I considered them to provide a plausible and holistic account of the social world. Children's wards are

socially complex places and fatherhood is a socially complex phenomenon. Use of Houston's (2010) domains of social life provided a framework for the discussion of that complexity. Nonetheless, these domains are largely untested as a framework for research, so using them was not without risk. Also Houston is a social work academic and Layder, on whose work Houston based his domains, is a social theorist; as such neither's work is widely known in nursing in general and children's nursing in particular, meaning that this thesis is grounded on unfamiliar ideas for a nursing audience.

In using such a framework, there is a danger of finding data to fit the framework- that is that the framework drives the research. This did not occur during my study as I only became aware of Houston's domains whilst I was exploring how to write up and present my findings. Thus, initial coding and determination of categories was emic and therefore was not guided by the domains. Once familiar with the domains, I attempted to map my categories to them, finding that all the categories mapped and all the domains had categories. This process in itself persuaded me of the utility of the domains as a framework to present the findings.

Whilst I have used the domains of the social world to structure the presentation of my findings, this has had the effect of fragmenting a complex whole and unavoidably resulted in some repetition. In reality, aspects from each of the domains were always present and interacting, interweaving, influencing or countering one another. Of course, breaking a whole down into its constituent parts does not then represent the whole but any textual representation of a multi-dimensual experience is inevitably partial or incomplete. Using the domains however did enable me to address both the micro and macro aspects of the social environment. So figure I.1 presents a conceptual map of the whole, showing how elements of each of the domains co-exist and combine to influence the father's experience.

9.11.3 Limitations of the study

There are a number of limitations to the study. Obviously it reflects the practice in one paediatric department in one hospital and a multisite study would have

enabled comparisons. Logistically as a fulltime employee and part time doctoral student, this was not possible.

Recruiting fathers to the study was challenging. Whilst the father interviewees were diverse in a number of ways- their own age, their child's age and length of stay, and ethnicity, I did not formally ask their occupation. With the exception of one, though, they were clearly middle class and well educated. This is in common with much of the research on fathers. The extent to which involved fathering is a middle class phenomenon remains a question within fatherhood scholarship, which this study does not resolve in relation to fathers of children in hospital.

Given the significance of work to fathers' experience which I discovered, more detailed information about their employment status and occupation would have enriched the study. Interviewing fathers after their child's discharge enabled them to contextualise their experiences.

In hindsight, I think that focus groups may have been more successful to collect data from nurses. I sometimes thought during nurse interviews that I was being given 'textbook answers'. I think I underestimated the effects my status as a nurse academic would have on nurses, and this influence may have been less significant in a group setting than it was in one to one encounters.

9.12 REFLECTING ON THE RESEARCH JOURNEY

A reflexive approach during a research project enables the researcher to understand the impact they have on the course of the whole study, including on participants, but also the impact that the study has on the researcher (Allen, 2004; Arber, 2006). Reflexivity therefore enhances credibility and reliability by making the position and judgements of the researcher transparent (Seale, 1999).

9.12.1 On being an insider and outsider

The identity of the ethnographer as an insider-outsider in the field is socially constructed and established through interactions with members in the field (Allen, 2004). Whilst I have found the conceptualisation of insider-outsider helpful as a prompt to reflect on my own position vis- a-vis participants during the course of the

study, I have also found it a simplification. In fact I held multiple positions along a continuum from insider to outsider and in relation to different groups within the study.

As far as the nurses were concerned, although a professional insider, I remained predominantly a social outsider, albeit one with some insider knowledge. At times however, if I was present for handover, I would be invited to join in informal tea breaks on the ward, suggesting I was a transient social insider. Organisationally, I remained an outsider, although nominally an insider with an honorary contract, a Trust ID badge and contact with the Trust Research and Development Department.

With the fathers, as a woman I was clearly an outsider- and yet at the same time I was a parent, as they were. It became evident that my shared status of parent was significant to both fathers and mothers. Almost without exception, parents with whom I spoke about the study asked me if I had children, suggesting that this had some value for them. It seems to me that my being a parent was point of connectedness with both fathers and mothers, just as being a nurse was point of connectedness with nurses, in the way that Williams (2009b) describes sharing masculine humour as point of connectedness. I found connectedness a helpful concept in considering relationships with participants, as I sought to gain acceptability as Arber (2006) described.

On having prior professional and experiential knowledge

Having prior professional and experiential knowledge of children's nursing practice proved to be both an advantage and a disadvantage. Being a nurse and nurse educator before I began the study meant that I inevitably had my own opinion on 'how things should be'. So for example at the start of the study I thought I knew where to observe – the clinical areas, the nurses' station, the playroom, but as I have shown, the corridor was an important place too, so I tried to respond to what was happening around me rather than my pre-conceived ideas.

I have earlier discussed how the person with prior knowledge can be both 'blind and seeing' in ethnographic terms. An example of being both blind and seeing as a result of my own prior experiential knowledge is my response to the ever-ringing

doorbell. Having been away from the immediacy of clinical practice for several years before the study, I was struck on my initial visits to the wards that the doorbell rang constantly. I found the sound immensely irritating and intrusive, yet the nurses frequently appeared not to hear it. Over time I too ceased to hear it. One day I observed two junior doctors sitting at the nurses' station; the doorbell rang constantly and they ignored it. Eventually a nurse came out of the high dependency area to answer it. I realised my previous observation had been focused on the nurses' response to the bell, because, like the junior doctors, I had made the assumption because of my previous experience that it was nurses only who could answer the doorbell.

The notion of 'guilty knowledge' and the dilemmas of the researcher who knows something they should not is discussed in the literature on ethnography (e.g. by Baillie, 1995), yet this was not an experience I had. As a nurse, I was able to, and in fact unable not to, form judgements about the standards of care that I observed. Whilst at times I felt care was less than ideal, I did not feel it was poor and therefore did not face a dilemma of choosing between a researcher's pledge of confidentiality and nurse's professional responsibility.

On relationships in the field

I was aware at the start of the study that some nurses avoided or ignored me, I think from distrust and uncertainty. I had warm, friendly relationships with others who would ask me how the study was going. I found over the course of the study, that by adopting a positive, friendly and non-judgemental attitude, I was able to develop trusting relationships with the majority.

Some nurses also approached me to suggest fathers to speak to or to tell me what I conceptualized as "father stories"- accounts of particular experiences with fathers in which the fathers were portrayed as heroes- super-involved, super- competent fathers, indeed in one nurse's telling phrase 'almost like a mother', or villains- lazy, negligent or uninterested. I interpreted these stories as nurses' efforts to be helpful, rather than to manage me. Given Allen's discussion of the roles of nurses' stories in professional life (Allen, 2004), further analyses of nurses' stories of

working with fathers and mothers may prove fruitful in furthering understanding of nurse/parent relationships.

As a children's nurse and educator I was aware before the study that a stereotype of the "angry father" is discussed informally by children's nurses. Within this study no nurses mentioned angry fathers to me in interview, which may demonstrate that they were wary of me, knowing my professional background. However I did observe dismissive comments being made by nurses in relation to fathers who expressed anger or frustration by complaining or trying to get something to happen. My interpretation was that social desirability bias exerted an influence on nurses during interview yet over the course of participant observation the effect of my presence during handover was reduced, as was shown by the labelling and stereotyping I witnessed. This finding demonstrates the value to the researcher of prolonged engagement in the field, but also caused me to reflect on what these episodes meant, particularly when some of the adverse comments about parents seemed to be directed directly to me.

9.12.2 On role tensions

When such remarks were made I perceived a tension between my role as a researcher and my professional identity as a nurse. I made no comment and endeavoured to show no response. I think such episodes were intentional challenges to the neutral position I had adopted, as tests to see whether I really was a spy after all, or whether I would assume an authority within the situation. Alternatively I may have been seen as an ally, who could 'tell it like it is' and thus give voice to the nurses' occupational frustrations. However this may be to assume a greater influence within the situation than I really had- these situations could equally have been naturally occurring episodes of 'back-stage talk' which participant observation over a prolonged period enabled me to witness.

Tensions arose at other times during participant observation also. There were times when I felt the ward was not being managed effectively and when I felt irritated by nurses' attachment to the nurses' station rather than spending time with parents and children- where I felt they 'should' be. However, as a nurse I was also aware of

the amount of co-ordination work that nurses do, which is away from patients' bedsides and therefore frequently invisible, yet which is vital to patients' experiences.

Although as a researcher, I wanted my presence to have minimal impact on the social action of the ward, there were times when I felt bound by my professional responsibility to alert a nurse to a situation. For example, there was an occasion when all the nurses were busy elsewhere and I found a teenage girl who was on her own sobbing inconsolably. I approached her to ask if I could help and offered to get a nurse for her. The nurses' slow response to my request and other similar situations gave me, in much reduced form, an insight into the frustrations a parent might experience as a consequence of forced dependency on others.

Being a nurse did give me an entrée with parents and enabled the establishment of rapport, as Darbyshire (1994) has described. Having had considerable experience in clinical practice with children and families, I was surprised how difficult it was to make an initial approach to parents in a researcher role. Rather than having knowledge and skills to offer I needed to ask parents to share their experiences with me. However, knowing I was a nurse may also have influenced what parents chose to share with me, even though I stressed my independence from the hospital.

My decision to share my status as a nurse and nurse teacher as well as researcher was based on a general approach of openness and honesty with all participants as far as possible. But I felt it also gave a legitimacy to my research- perhaps to myself as much as to others. This was always a research project with the purpose of potentially improving practice through increased knowledge.

Whilst parents did not ask me clinical questions, they did at times ask me for my general opinion about the care on the wards. In a spirit of openness and honesty I found these questions difficult. At such times I shared my opinion in very general terms about, for example, facilities for parents but did not disclose my personal opinion about the specific care their child received nor any particular nurse's practice.

I was also surprised by my emotional responses to some of what I saw. I found it distressing to see children in pain for example, yet this was my everyday experience when I was in practice. Again I think these arose from a sense of frustration because I was not clinically involved in the situation and therefore had to respond in a way that ran counter to my professional socialisation.

9.12.3 On gender

Gender is always present in any human interaction. During participant observation, I did find that I had some conversations with mothers on their own when conversations took on an almost conspiratorial 'you know what men are like' tone which would not have occurred had I been male and which, of course, it was impossible to have with fathers.

Williams and Heikel (1993) maintain that interviews always take place in a gendered context, be that of gender similarity or difference and I felt most aware of gender during the interviews with fathers. Aull Davies (2008) argues that understanding cannot be assumed as a consequence of researcher and participants being of the same gender. There is some discussion in the literature on the effects of gender in interview. Williams and Heikel (1993) argue that there is a general view that men are more comfortable talking to women, rather than men, about intimate topics and Arendell (1997) felt that men talked to her in depth and detail about divorce *because* she was a woman, rather than a man. On the other hand, Williams (2009b) discusses the advantages to his research of being able to join in with participants' masculine humour during interviews.

I have discussed earlier how I dressed the same way in interviews as on the wards in an effort to downplay the effect of gender. I found that the majority of fathers spoke readily to me in depth and detail about their personal experiences. This may have been because only those fathers who were willing to speak to a woman about such issues agreed to be interviewed, so it is not possible to draw any broader conclusions.

Pini (2005) and Manderson *et. al.* (2006) also argue that interviews can be influenced by other factors relating to the researcher, besides gender, including

age, race and class, and this was the case in this study too. I felt for example that the most challenging and least successful father interview was with a father from a different racial background to my own. In interviewing fathers predominantly at home, I inevitably formed judgements relating to their class, from their address, their home and its contents. I was acutely aware during interviews therefore that they had disclosed considerably more about themselves than I had about me, although one could argue that by presenting myself to them as a nurse I had declared my class.

I had not envisaged that mothers would feature as they did in terms of gatekeeping my access to fathers and joining in during interviews. In retrospect I consider that these couple interviews add to the study- the interactions between them were revealing and parents had experienced the child's hospital admission as a couple after all, so it should not have been surprising that they wished to share their experiences. I do however also feel that these mothers revealed how they were themselves unable to countenance a discussion of their child's care that did not involve them. This is a further example of maternal gatekeeping. I think my study is richer for their involvement, though. Nonetheless, for me, it re-enforces my perception that mothers see matters relating to ill children as *their business.*

Throughout this study, I have asked myself why I as a woman was investigating this topic. I explained the origins my professional interest in fathers in the introduction to this thesis. I cannot explain why any male children's nurses have not investigated fathers' experiences. Given the pre-conceptions about male children's nurses of some of the participants in my study, being a woman may actually have been advantageous.

Whilst the children do not feature in this thesis, this is because I took the decision on an ethical basis not to refer to them. They were though present in the study- they were of course, there on the wards when I spoke to parents, they were in fathers' arms when I did interviews, their voices are on the audio-recordings. Their views on family-centred care are important too and are yet to be investigated.

9.13 THE IMPLICATIONS OF THE STUDY

The study presented here has a number of implications, for current practice, for nurse education, for policy makers and for future research.

9.13.1 For practice

The wards on which the study was based are in a reasonably modern District General Hospital, yet facilities for parents were minimal. Lee (2007) has argued that poor facilities for parents indicate a lack of respect for parents as partners. My findings demonstrate a need for a review of the facilities available to parents staying with their children, which may well extend beyond that particular setting. Nurses need to advocate for appropriate provision and could be more pro-active in the use of space. In doing so, nurses need to ensure provision is made for fathers and mothers.

It is too easy for nurses and other health care professionals to accept a mother's not mentioning a father means that a father is not relevant to his child's life Nurses need to record data about the fathers of all the children they care for, even if that father is not resident with the family, and to recognise that a child may have a social father too.. Forms can be designed to do this in a non-stigmatising way – for example by asking for who is resident in the household and their relationship with the child; this would also overcome the heteronomative assumptions inherent in current documentation.

There is also clearly a need for nurses claiming to practice family-centred care to have regard for other family members, beyond the parent and child in front of them. Nurses also need to be conscious of the fact that for the family, the child's admission to hospital is not the start of their experience, nor the child's discharge the end of it. The stay in hospital is one disruptive stage in the journey, even of relatively minor acute childhood illness.

This study also provides further evidence of the reality of family-centred care in children's nursing practice falling short of that which is described in the literature. Carter (2008) suggests that children's nurses need to engage in further critical debate about the concept whilst Lambert (2009) has suggested that family-centred

care is so cherished within the profession as to be beyond critique. It would seem that children's nurses continue to maintain that they practice family-centred care, in the face of evidence that if they do it is in a superficial way, because they see it is what makes their practice unique from other fields of nursing. Therefore it is likely to continue to be claimed as a central tenet in theory whilst not being implemented, until such time as an alternative model is developed and gains credence.

9.13.2 For nurse education

None of the nurses interviewed or any that I spoke to informally had received any preparation for working with fathers. Nurses also showed limited understanding of the far –reaching impact of the child's admission, or how family members respond as a team. This is surprising given the emphasis on family-centred care within the profession. Yet there is a considerable scholarship of fatherhood, motherhood and the family. There is clearly a need for nurses to be better prepared to work with fathers, if fathers are to be treated as equal partners in care, with their needs recognised by nurses.

Nurses also need an improved awareness of all aspects of gender – how it functions in society as a whole, their own gender based assumptions and those that others might have. They would then be in position to recognise and challenge institutional gender bias.

Children's nursing as whole needs to decide whether it is going to persist in claiming to negotiate parental involvement when this study is the latest in a succession of research that demonstrates this is not what they actually do. If we continue to claim to negotiate, nurses must be properly trained in doing so, to be able to take into account during that process the vulnerability of the anxious, sleep deprived parent of an acutely ill child.

9.13.3 For policy

Clearly there is a need for children's health policy to acknowledge that parents are in fact mothers and fathers- use of the words 'mothers and fathers' in place of 'parents' would make this explicit. When standards for hospital facilities for

children are developed, they should reflect that the resident parent could be male or female, with appropriate facilities for both.

Current parental leave provision does not meet the needs of the family dealing with sudden acute childhood illness. There is a need for this to be reviewed to see whether arrangements could be made sufficiently flexible as to enable parents to take the necessary time off work, whilst still being manageable for employers.

9.13.4 For future research

All the father interviewees in this study were biological and co-resident with the family. There is a need to explore the experiences of a wider range of fathers, including young fathers, non-resident fathers, social fathers, gay fathers and fathers bringing their children up alone.

The concept of complementarity within the couple relationship has potential to be a useful concept for nurses working with families. At present it is ill defined but warrants further investigation and development.

Further exploration on the influence of gender on relationships between nurses and parents would yield greater understanding on an area which has been overlooked in previous research. In particular an investigation of male children's nurses' experiences and relationships with parents is warranted.

This thesis contributes to a growing body of evidence that fathers experiences their children's health problems and health care differently from mothers. Therefore in future research on parents, there is a need to take steps to include fathers, not just mothers, in study populations and to be explicit whether fathers or mothers are being discussed.

10.1 THE CONTRIBUTION OF THIS THESIS TO THE KNOWLEDGE BASE FOR CHILDREN'S NURSING

In answering the research questions as set out in the preceding section and as represented in the model in Figure I.1, I have begun the development of an understanding of fathers' experiences when their child is admitted on an unplanned basis following acute illness and injury and what influences these experiences. In this thesis, some further insights are also identified.

Embodied aspects of parents' experiences whilst on children's wards and fathers' embodied relationships with their children are important dimensions that have been paid little attention in earlier research. Furthermore, attention to parents' physical needs, in addition to their psychological needs is required.

This study has further brought into question the reality of the practice of family-centred care and parental partnership in care. This is a continuing challenge to children's nursing. It may be an ideal model which is unachievable in practice. If that is so, perhaps it is time to acknowledge its contribution to the development of practice and consign it to history. As it has been claimed to be central to children's nursing practice for so long, this would leave a large space which would need to be filled by an alternative children's nursing theory.

10.2 APPLICATION OF KNOWLEDGE FROM OTHER FIELDS TO NURSING PRACTICE

The knowledge base for children's nursing is eclectic. In constructing this thesis, I have brought together knowledge from a range of fields, namely: the sociology of gender, the scholarship on fatherhood (itself diverse and multi-disciplinary) and family and parenting studies, in addition to children's nursing research, applying

them to a nursing context. In doing so, I have brought new insights to bear on children's nursing, but have also shown that nurses as practitioners with parents have insights and contributions to make to these other academic disciplines.

10.3 CLOSING REMARKS

As an ethnographic account, this thesis represents my personal interpretation of fathers' experiences during their child's unplanned admission to hospital and their relationships with nurses. I chose what to observe, where to go, who to speak to, what to make note of and what to ignore. It is not claimed to be *the definitive account* of fathers' experiences, rather it is *an* account, albeit grounded in the data I collected.

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Appendix 3.1 Participant information sheets

Participant information sheet (fathers)

Fathers as partners in care: an exploration of fathers' experiences of their child's hospital admission

I would like to invite you to take part in a research study.

Please read this information before you decide whether to join in. You may discuss this with others before you decide and please ask me about anything you feel is unclear [redacted]

The purpose of the study

I am an experienced children's nurse and teach student children's nurses. I am undertaking this research as part of course at Swansea University.

Children's nurses work in partnership with families to provide care for children in hospital. Previous research has looked at parents' experiences when their child is in hospital but these studies have involved mostly mothers. There is evidence from other countries that fathers and mothers have different experiences of their child's health care. I am interested in finding out about fathers' experiences so that children's nurses can be better prepared to meet fathers' needs in future. I want to talk to fathers what it is like for them being the father of a child in hospital. I will also talk to nurses about involving fathers in care.

Why have you been invited?

I am asking the fathers of children unexpectedly admitted to the XX Hospital if they want to take part.

Do you have to take part?

It is up to decide whether to take part or not. You will have time to decide whether you are interested or not.

You are free to withdraw at any time and do not have to give a reason.

Your decision will not affect the care your child receives in any way.

What will happen if you decide to take part?

I will contact you in writing once your child has been discharged. If you wish to take part, I will arrange a convenient time and place to interview you. The interview will

last 40-60 minutes and be audio-recorded. Anonymous quotations from the interview may be used in any subsequent written reports and publications.
I may also look at your child's nursing notes if you agree.
I will compare what you say with what other fathers and nurses said. I will send you an account of the findings for you to comment on and return to me.

Expenses

I will reimburse you for any travel costs incurred for the interview.

What are the possible benefits of taking part?

I cannot promise the study will help you. Information from the study will help nurses in future be more aware of fathers' needs when their child is in hospital.

What if there's a problem?

The study has been approved by xshire Research Ethics Committee and X NHS Trust's Research and Development. If you do, however, have concerns or a complaint about the way you have been dealt with during the study, these will be addressed. Please contact the researcher in the first instance [redacted] If you remain unhappy and wish to complain formally please contact x, Paediatric Nursing Manager on [x] or Dr Ruth Davies, the supervisor of the research at Swansea University [redacted]

Will your taking part in the study be kept confidential?

Yes. Hospital staff will not know whether you take part or not. I will follow ethical and legal practice. All information about you will be handled in confidence.
Thank you for taking the time to read and consider the request.

Please tear off, complete and return the slip below to me if you wish to take part

---

Name:

Name of child patient:

Contact details:

Participant information sheet (nurses)

Fathers as partners in care: an exploration of fathers' experiences of their child's hospital admission

I would like to invite you to take part in a research study.

Please read this information before you decide whether to join in. You may discuss this with others before you decide and please ask me about anything you feel is unclear.

The purpose of the study

I am an experienced children's nurse and teach student children's nurses. I am undertaking this research as part of course at Swansea University.
Children's nurses work in partnership with families to provide care for children in hospital. Previous research has looked at parents' experiences when their child is in hospital but these studies have involved mostly mothers. There is evidence from other countries that fathers and mothers have different experiences of their child's health care. I am interested in finding out about fathers' and nurses experiences so that children's nurses can be better prepared to meet fathers' needs in future. I therefore want to talk to fathers and nurses about working together.

Why have you been invited?

I am asking all band 5 and 6 nurses on the paediatric unit whether they want to take part because nurses of these grades are those most involved with working closely with families to plan and deliver care.

Do you have to take part?

It is up to decide whether to take part or not. You are free to withdraw at any time and do not have to give a reason. Deciding not to take part will have no effect on your employment.

What will happen if you decide to take part?

I will contact you to arrange a brief interview at a mutually convenient time.

The interview will be audio recorded, typed up and compared with those from other nurses and fathers, looking for common themes. When the analysis is complete, I will send you an account of the findings for you to comment on and return to me. Anonymous quotations from the interview may be used in any subsequent written reports and publications.

Expenses

I will reimburse you for any travel costs incurred for the interview.

What are the possible benefits of taking part?

I cannot promise the study will help you but information from the study will help nurses be more aware of fathers' needs when their child is in hospital.

What if there's a problem?

The study has been approved by xshire Research Ethics Committee and X NHS Trust's Research and Development. If you do, however, have concerns or a complaint about the way you have been dealt with during the study, these will be addressed. Please contact the researcher in the first instance [redacted] If you remain unhappy and wish to complain formally please contact x, Paediatric Nursing Manager on [x) or Dr Ruth Davies, the supervisor of the research at Swansea University [redacted]

Will your taking part in the study be kept confidential?

Yes. Other members of hospital staff do not need to know whether you take part or not. I will follow ethical and legal practice and all information about you will be handled in confidence.

Thank you for taking the time to read and consider the request. I will contact you shortly to ask whether you wish to take part.

Notice to children

Hello, my name is Sue Higham. I am a children's nurse finding out about parents and nurses working together to look after children and young people in hospital.

I may ask you if I can watch things that happen while you're in hospital or talk to your parents about how they work with nurses to look after you.

If you don't want me to talk to your parents, please let your nurse know.

If you want more information please ask me.

Notice to parents and visitors

My name is Sue Higham. I am a children's nurse doing a study at X from September 2008 to March 2010. The study is part of a course I am doing at Swansea University and has been approved by X Trust Research and Development Unit.
I am looking at parents and nurses working together. I may ask you if I can observe aspects of your child's care or if I can interview you.

You are free to say no to any such request at any stage. This will not affect your child's care in any way.

If you want more information please ask me- in person or by email.

Contact details:
[redacted]@swan.ac.uk
Or [redacted]

Appendix 3.2 Approval letters

NHS

NHS Foundation Trust

Research and Development Office

2nd July, 2008

Sue Higham
Lecturer Children's Nursing
Open University, Walton Hall
Milton Keynes
Bucks, MK7 6AA

Dear Sue,

RE: Fathers are partners in care: an exploration of fathers' experiences of their child's hospital admission

REC Ref number: 08/H050574
SSA Ref number:
Protocol number: Version 5, dated 4h April 2008
EudraCT number:

This study has been reviewed and approved ; Foundation Trust.

Please may we remind you that R&D should be informed of any amendments to the Protocol, closure of the study or any changes made during the course of the study. Annual progress reports should also be sent to R&D every year from the start of the study until completion.

If you are the Chief Investigator for this study, the Ethical Committee which gave a favourable ethical opinion for the project should also be informed of the above.

We would also like to take this opportunity to remind you of your responsibilities under the terms of the Research Governance Framework for Researchers, Chief Investigators, Principal Investigators and Research Sponsors. These are included with this letter for your reference.

We wish you all the best with the study.

Yours sincerely,

Leslie Frederick
R&D Manager

NHS
National Research Ethics Service
[redacted] Research Ethics Committee
National Research Ethics Service
[redacted] Research Ethics Committee
Building L27
University of Reading
London Road
Reading
RG1 5AQ
Fax: 0118 378 0339

24 July 2009

Ms Sue Higham
[redacted]

Dear Ms Higham

Study title:	**Fathers as partners in care: an exploration of fathers' experiences of their child's hospital admission**
REC reference:	**08/H0505/74**

Thank you for sending the progress report for the above study dated 02 July 2009. The report will be reviewed by the Alternate Vice Chair of the Research Ethics Committee, and I will let you know if any further information is requested.

The favourable ethical opinion for the study continues to apply for the duration of the research.

08/H0505/74:	**Please quote this number on all correspondence**

Yours sincerely

Slee

Ms Lavenda Lee
Assistant Co-ordinator

E-mail: scsha[redacted]rec@nhs.net

Copy to: *Dr Ruth Davies, Swansea University*
R&D office for NHS car organisation at lead site

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NHS
National Research Ethics Service
[redacted] Research Ethics Committee
Building L27
University of Reading
London Road
Reading
RG1 5AQ

Telephone: 0118 918 0550/1
Facsimile: 0118 918 0559

16 June 2008

Ms Sue Higham
[redacted]

Dear Ms Higham,

Full title of study: **Fathers as partners in care: an exploration of fathers' experiences of their child's hospital admission**
REC reference number: **08/H0505/74**

Thank you for your letter of 08 June 2008, responding to the Committee's request for further information on the above research and submitting revised documentation, subject to the conditions specified below.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). There is no requirement for [other] Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission at NHS sites ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Application	1	21 April 2008
Investigator CV		06 April 2008
Protocol	5	04 April 2008
Covering Letter		22 April 2008
Summary/Synopsis	1	04 April 2008
Letter from Sponsor		21 April 2008
Participant Information Sheet: Nurse	3	01 June 2008
Participant Information Sheet: Father	3	01 June 2008
Participant Consent Form: Nurse	3	01 June 2008
Participant Consent Form: Father	3	01 June 2008
Response to Request for Further Information		08 June 2008
Letter of invitation to father	1	06 June 2008
Research Governance Framework - check list		21 April 2008
UMAL Insurance		01 August 2007
Notice to children	1	04 April 2008
Notice to parents & visitors	2	04 April 2008
CV: R Davies		09 April 2008

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

08/H0505/74	Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely

Professor Nigel Wellman
Chair

Email: scsha.[redacted]srec@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: *Dr Ruth Davies, Swansea University*
R&D office for NHS care organisation at lead site

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This Research Ethics Committee is an advisory committee to South Central Strategic Health Authority

The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England

Appendix 3.3 Consent forms

Consent form for fathers

Participant identification code:

Title of project: Fathers as partners in care

Name of researcher: Sue Higham

Please initial box

1. I confirm I have read and understand the information sheet dated..... (version.....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily ☐

2. I understand and agree that the interview will be recorded and anonymous quotations may be used in written reports. ☐

3. I understand my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my child's care or legal rights being affected ☐

4. I agree to take part in the above study ☐

5. I agree to Sue Higham having access to my child's nursing notes for the purpose of the study ☐

----------	----------	----------
Name of participant	**Date**	**Signature**

----------	----------	----------
Name of person taking consent	**Date**	**Signature**

Consent form for nurses

Participant identification code:

Title of project: Fathers as partners in care

Name of researcher:

Please initial box

1. I confirm I have read and understand the information sheet dated..... (version.....) for the above study. I have had the opportunity to consider the information and ask questions which have been answered satisfactorily ☐

2. I understand and agree that the interview will be recorded and anonymous quotations may be used in written reports. ☐

3 I understand and agree that nursing records may be reviewed as part of the study ☐

4. I understand my participation is voluntary and that I am free to withdraw at any time without giving any reason ☐

5. I agree to take part in the above study ☐

----------	----------	----------
Name of participant	**Date**	**Signature**

----------	----------	----------
Name of person taking consent	**Date**	**Signature**

Appendix 3.4 Interview topic guides

Interview guide for fathers

Name Age

Name of child Child's age

Child's length of stay: Ward:

Father resident in hospital overnight:

Previous experience of having a child in hospital:

Could you tell me the story of your child's stay in hospital from your own point of view?

What did you do when your child was in hospital?

Do you think the nurses were aware of your needs as a father when your child was in hospital?

Did you feel like a partner in the care of your child in hospital? Did the nurses negotiate care with you?

Is there anything else you'd like to say?

Interview guide for nurses

Could you tell me your understanding of family centred care?

What is your role in working with families?

Could you tell me about any training you have had to work with parents and fathers in particular?

What do the fathers you work with do?

Could you tell me about your experiences of working with fathers?

Is there anything else you would like to tell me about working with fathers?

Appendix 3.5 Examples of coding, categories and mapping onto domains

Extract and source	Coding	Category	Domain
I wouldn't want to choose any other place to be because I wanted to make sure she was okay (Greg, father interview)	Physical presence	Being there	The domain of the person
I think it was more about the nitty gritty of what was going to happen and when, not in terms of the standard every day sort of care that you give to a child like washing, dressing, blah blah, I think they kind of .. yeah they left it up to us really. (Zack, father interview)	Left to get on with it	Nurses and fathers as co-workers	The domain of situated activity
Well I suppose, everybody if mum's there, like the doctors, you tend to .. you *do* tend to speak to mum more (Tracey, nurse interview)	Ward routine as a barrier	Ward routines	The domain of social settings
J: She was in for three nights? *(looks at Sam his wife to check, she says mmm)* Yeah three nights in the end. (Jake father interview I certainly got some comfort from the fact that it was all a well-oiled machine but that in the middle of it *there was a mother (Chris father interview)*	Mother as authority	Gender ideology	The domain of culture
If your child's in hospital I think it's easier for a mum- its an instinct isn't it – for mum to want to be here all the time (Tracey nurse interview)	Mothers are the natural carers		
At my work the compassionate leave is down to my line manager so she just said "take it all off if you want" but I didn't want to leave my team and there was difficulty with other stuff that was supposed to be going on so I did a bit of work.	Juggling work and care	Parents work	The domain of polity and economy