Fathers’ roles when their child is in hospital

Since the 1990s, family-centred care has been widely promoted within children’s nursing and UK health policies (Davies, 2010). Shields et al (2006) define family-centred care as “a way of caring for children and their families in health services that ensures care is planned around the whole family, not just the individual child/person and in which all the family members are involved as care recipients.”

Although Darbyshire (1994) states there is a need to understand the hospital experiences of both parents, Mikkelsen and Frederiksen (2011) argue family-centred care has been built on a narrow understanding of the family, based mainly on the views of mothers. Macfadyen et al (2011) also suggest that much of the research on parents’ experiences of hospital has focused on mothers.

Fathers are becoming increasingly involved in their children’s lives (Ivens, 2010), including in their healthcare. Nurses therefore need to understand fathers’ perspectives in order to fully involve them in care. In the UK, a small number of hospital-based studies of parents’ experiences of their child’s hospitalisation include a minority of fathers. These studies provide glimpses of fathers’ experiences:

» Darbyshire (1994) found fathers were largely ignored by nurses and marginalised by organisational policies that understood “parents” to mean mothers;

» Callery (1995) found fathers were involved in care as “substitute mothers” or as an optional extra;

» Coyne (2003) found fathers supported mothers by relieving them at the child’s bedside and sharing duties at home.

While there has been some research into the experiences of fathers of children in hospital, fathers’ roles when their child is hospitalised are often overlooked and underestimated, and they are not equal partners in care.
with long-term conditions, little research has focused on understanding fathers’ experiences when their child is admitted to hospital for acute illness (Higham, 2011). Given the trend for greater involvement, fathers may be more active agents during their children’s hospitalisation than has been identified previously.

**Aim**

The aim of the study was to gain an increased understanding of fathers’ experiences during their child’s stay on a children’s ward in a district general hospital following an unplanned acute admission.

**Method**

We used an ethnographic design, including participant observation and interviews with fathers and nurses. These took place on two children’s wards of a district general hospital in an acute trust in the South of England.

We interviewed 12 fathers after their children had been discharged. Observation focused on day-to-day activities, including admissions, handovers, ward rounds, interactions between fathers and nurses, and conversations with fathers, mothers and nurses.

Data was analysed using the two-stage approach of coding and interpretation recommended for use in ethnography by Brewer (2000).

**Ethics**

The local research ethics committee gave approval and all participants gave written informed consent.

**Results**

Three roles adopted by fathers during their child’s stay were identified: protecting; providing; and participating in care.

All the fathers we interviewed adopted these roles, although they varied in how much significance they gave to each.

**Protecting**

Fathers were observed undertaking a range of protective behaviours and discussed the importance of protecting their children and partners. This included having a physical presence and “being there”. For example: “I wouldn’t want to choose any other place to be because I wanted to make sure she was okay.”

They reported a need to “be strong” for other family members and to adopt an advocacy role, which could include challenging staff if they felt care for the child or mother was lacking.

**Providing**

In this study, providing behaviours included: ensuring others’ needs were met, providing care and working.

Some fathers continued to work while their child was in hospital, although all had time off at some stage. Fathers spoke of the emotional impact their child’s illness had on their work, for example: “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…. Obviously I’m affected personally emotionally so … that was the first time I took time off, just left work in the morning and went straight to the hospital.”

Fathers frequently brought in food and clothes for resident mothers and children and described their struggle to juggle their working and caring responsibilities. However, nurses were largely unaware of this aspect of fathers’ contributions, tending to only see resident fathers as “involved”.

**Participating**

Most fathers discussed how they and the child’s mother had participated in the overall care of the child and wider family. Fathers participated in several areas by:

- Sharing the caring;
- Assisting with clinical care;
- Decision-making.

Some couples adopted a “shift” system, so their child had one parent there 24 hours a day.

**Discussion**

The fathers involved in the study made active contributions to their child’s care in hospital, directly or indirectly by supporting the mother and caring for siblings. However, mothers were generally seen by their partners and by nurses as the primary carer. Consequently, fathers were not always involved as equal partners in their child’s care and family-centred care appeared to relate to mothers or resident parents, rather than the whole family.

Fathers described an emotional need to be physically present with their sick child. This need for physical presence, particularly during painful procedures, had a protective element and is similar to the strong protective feelings identified by McNeill (2007) among fathers of children with long-term conditions. Fathers “need to be strong” may be important to family coping in the short, medium and long term. However, this could lead nurses to assume that fathers do not need emotional support, particularly when relationships between fathers and nurses are short term.

**Limitations of the study**

This study represents one hospital. The small sample of fathers may have different attitudes towards fathers’ roles from those who declined to take part. All fathers interviewed lived with the child and mother and there were few younger fathers, representing only a section of fathers in general.

**Conclusion**

This study has shown fathers to be active participants in the care of their children in hospital adopting protecting, providing and participative roles. However, many were not equal partners in care. While fathers were often seen as marginal to the child’s admission, they were an essential part of the family’s experience.


**References**


