ABSTRACT

Situational Role Management:

A Study of Parental Behavior in the Pediatric In-Patient Setting

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The substantive focus of this study is parental behavior in the pediatric in-patient setting. Field research is employed as the method of scientific investigation. The research problem that emerged from the data is: In the absence of an organizationally structured formal position and role for parents of hospitalized children within the hospital system, how do parents determine what their role in the setting will be? The social setting of the hospital as well as parent-staff interaction were taken into account in this investigation of parental behavior.

The study was conducted in the pediatric in-patient units of three general hospitals within a large metropolitan city: a university hospital, a country hospital, and a private hospital. Approximately 180 hours of observation and 55 interviews - 22 with parents, 23 with nursing staff and 10 with inter-disciplinary professionals in the settings provide the data for the analysis.

Using the technique of constant comparative analysis data collection, coding and analysis occurred simultaneously. Key categories delineating the factors found to influence parental behavior, and the core category explaining the variations in

parental behavior, were abstracted from the data to form the basis for the proposed theory.

The research problem of this study is addressed through an analysis of the theory of Situational Role Management. Situational role management is defined in this study as the process of directing one's behavior with regard to conditions and attendant circumstances in order to achieve a goal.

The theory of situational role management is a grounded substantive theory and represents a conceptualization of the attempts on the part of the parents as non-professionals to enter into the domain of the health professionals and to determine their place and role within the hospital system.

Situational role management is comprised of three interrelated aspects: situational factors that exist in the setting which affect parental role management; phases of role management which signify the current relationship between the parents and others in the setting, and progress in their movement toward inclusion into the system; and implementing processes, the means parents utilize in their efforts to manage their role.

The four situational factors or key categories found to be relevant are orientation, structure of work, balance of power, and information exchange. Orientation is the philosophical perspective of a group or person toward another group or person that sets the stage for their interaction. The structure of work takes into account the kinds of activities done in the setting and the persons who

share in the division of labor. Balance of power refers to the control aspects of a situation. Information exchange refers to the transmission and receiving of messages in the setting, and is viewed both as a source of communication and a means of social control. Cross-cutting these categories are the temporal aspects and territorial boundaries. Each of the categories is presented in a manner that shows their relationship to parental behavior and parent-staff interaction.

The second aspect of situational role management focuses on the phases parents go through in the process of managing their role. Three phases emerged from the data: parent-setting stress characterized by conditions of ambiguity and uncertainty for the parents; parent-setting conflict, during which there is opposition between the parents and the health professionals in the setting; and parent-setting fit, characterized by consensus between the non-professional and the health professional regarding their respective roles in the setting.

Within each phase of situational role management there was found to be corresponding implementing processes utilized by the parents. Defining/re-defining are the implementing processes in the phase of parent-setting stress; balancing/negotiating occur in the phase of parent-setting conflict; and settling is employed in the phase of parent-setting fit. These implementing processes are further broken down into behavioral strategies.

Situational role management was found to be an on-going process of role determination influenced by changes in conditions. The phases of situational role management are therefore not fixed and parents enter and/or re-enter any of these phases throughout a given hospitalization.

Finally, implications of the theory of situational role management for health professionals in the practice of pediatrics and family health are presented. Limitations of the study, as well as suggestions for future research are identified.

Dorothy S. Ada
Chairperson

9-14-77
Date

To my Father and Mother

Charles and Virginia Kurczynski

for their never-ending

love and support

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CHAPTER I

RESEARCH PROBLEM AND GUIDING PERSPECTIVES

This research was designed to systematically study parents of hospitalized children in order to identify relevant factors that influence parental behavior in the pediatric in-patient setting, and to discover the social processes inherent in interaction between non-professional family members and the health professionals in the hospital setting. This study represents an attempt to add to already existing knowledge regarding the family and health care and to address the larger issue of the role of the family in health and illness.

The family is a basic social unit of society. When illness of a family member requires hospitalization, the result for the family unit is separation of the sick person from the rest of the family. The person who is ill becomes temporarily incorporated into the hospital system while the family is often relegated to the position of being outside of the system and viewed as beyond the scope of concern of the health professional. Health professionals in their attempts to provide individualized patient care have at times neglected to take into consideration the family unit of which the patient is a member. Because of the interdependency of family members, the illness of one person affects all the members and to some extent modifies the entire family structure. According to Bell (1969), rather than viewing the patient and family as separate,

what is needed if the family system is to maintain itself is "functional interaction in which the relating parts [family and hospital systems] have been able to maintain their structure" (p. 25).

In the area of pediatric health care, attention is being directed toward greater incorporation of the entire family in the care of the sick child, not only in terms of ambulatory care, but in the hospital setting as well. In the first half of the 20th Century when children were admitted to the hospital, parental visiting was institutionally controlled and minimal restricting parental access to the child and to the health professional. Concern existed that the spread of infection and communicable disease would result from unlimited visiting. Pediatric staff viewed parents as outsiders and often perceived them to be a hindrance to the delivery of professional care and the efficient functioning of the unit. Emphasis was placed on the individual child and his illness rather than on the family as a unit.

During the past twenty-five years a change in hospital policies relating to sick children and their families has evolved. Liberalization in philosophy and practice regarding pediatric in-patient care has resulted in an increased number of hospitals that provide rooming-in facilities for parents, promote open visiting, and encourage active participation of parents in the care of their child.

Several factors are responsible for the changes in thinking and practice. The use of vaccines and immunizations markedly

lessened the incidence of communicable disease, and the use of antibiotics decreased the concern regarding cross-infections (U.S. Bureau of the Census, 1971). The research and writings of psychologists, psychiatrists, pediatricians, and nurses stress the detrimental effects of hospitalization and separation especially for children four years of age and younger, and emphasize the need to humanize the care of children of all ages and their families in the hospital (Bowlby, 1952; Prugh, et al, 1953; Blake, 1954; Robertson, 1958; Shore, 1967; Haller et al, 1967; Lindheim, et al, 1972; Petrillo and Sanger, 1972). In addition, family theory supports the need to consider and care for the total family as an interdependent unit (Ackerman, 1958; Satir, 1967; Keane, 1970).

Further, local, state and international interdisciplinary organizations have been formed for the purpose of improving care of children and families in hospitals (Hardgrove, 1975). Consumer demands concerning the right to obtain quality care and information regarding care have been influential in changing hospital policy. A combination of the above factors has been significant in fostering a more family oriented approach in pediatric health care.

Specific Problem

The substantive area of this study is parental behavior in the hospital setting. The specific problem which emerged in this research was: In the absence of an organizationally structured, formal position and role for parents of hospitalized children within the hospital system, how do parents determine what their role in

the setting will be?

The social environment of the pediatric unit was the context within which parental behavior was observed. The pediatric units of three general hospitals were selected as the study sites for this investigation.

Although parents are spending more time with their hospitalized children, there is no established position for them within the hospital structure and their role in the setting remains unclear and ambiguous (Hardgrove and Dawson, 1972). Parents and nursing staff often differ in their self-expectations and the expectations they have of each other. A lack of parental role clarity and specificity in the hospital setting results in confusion, poor role enactment, role strain, and added stress in an already stressful situation.

This researcher recognized that parents differ in the amount of time they are present with their hospitalized child and that individual parents also vary in their behavior within the hospital setting. This study is an attempt to identify the factors existing in the setting that influence parental behavior, describe the conditions under which specific behaviors occur, determine similarities, differences and variations in the patterns of behavior, and analyze the consequences resulting from that behavior for the parents and those with whom they interact.

Study Focus

Rather than attempting to verify preconceived hypotheses, factors defined as key categories influencing parental behavior and social processes involved in interaction were the foci of this inquiry. The aim of this study was not to determine the frequency and distribution of the problems and processes addressed, but to delineate the conditions under which they occurred, the variations in the processes and the consequences of these variations in order to weave a dense theoretical scheme that would serve to explain the behavior under investigation.

Among the questions addressed during the course of data collection and analysis were:

1. What accounts for variations in the behavior of parents of hospitalized children in relation to parental role performance? Does an overall pattern to this behavior exist? What factors in the setting influence the behavior of parents in their entry as non-professionals into the domain of the health professional? What are the consequences of these factors for parental behavior?
2. What do parents see as their parenting role in the hospital setting? How is this related to the role of the staff? What strategies do parents utilize to assist them in giving meaning to the situation and determining their role? How do parents go about making a place for themselves in the divisions of labor with regard to the care of their child?

3. In the presence of differing staff philosophies regarding parents in the hospital setting, how do parents locate their position within the system and determine their consequent role behavior? How do parents handle opposing views between themselves and the staff as to what their role in the care of the child will be? What is the effect of knowledge and experience on parental role determination?

Questions such as these served to guide the observations, interviews, and analysis in this study. The focus of this study was on interaction between the parent and staff and the meaning attributed to these interactions by the individuals in the setting.

Literature Related to Parents of Hospitalized Children

Recent literature concerning parents in the hospital consists mainly of the reporting and evaluation of existing rooming-in and parent participation programs in pediatrics. Much of this literature is of a descriptive nature and stresses the physiological and psychological benefits for the child and the psycho-social benefits to the family and staff that result from parental presence and participation in care (Aughauser, 1967; Condon and Peters, 1968; Shoppe, 1970; Hardgrove and Dawson, 1972). The writings, however, contain minimal description of the influential factors in parent-staff interactions, the consequences of the interactions, or the social processes involved.

Hospitalization of a child necessitates alteration in family roles. Mahaffy (1964) found that a lack of clarity between the nurse and the parent regarding their roles and functions resulted in tension, stress and breakdown of communication. Merrow and Johnson (1968) administered a questionnaire to 50 mothers and 50 registered nurses in the hospital setting regarding their perceptions of what the mother's role in the hospital should be. In the majority of cases mothers preferred to be responsible for more aspects of the child's care than the nurses realized. The results of a study by Beck (1973) indicated that different functions and responsibilities in the hospital setting evoke a variety of responses from parents. Mothers favored helping the child with activities of daily living and giving emotional support, were uncertain about unfamiliar technical procedrues, and were opposed to being in the way or upsetting hospital routine. A study that stresses the influence of parent-staff interaction on parental behavior is that done by Roy (1967). Her study results support the hypothesis that appropriate role cues from the nurse significantly improved the adequacy of maternal performance in caring for the hospitalized child.

Studies dealing with parental roles in the hospital focus on the maternal role making no mention of the role of the hospitalized child's father. In an attempt to identify the concerns of the father in the hospital, Ieni (1975) used a questionnaire and elicited responses from 20 fathers of hospitalized children.

Although the sample is small, 50% of the respondents said that maintaining the father role with the child was of concern to them. The research to date indicates that role performance on the part of the parent in the hospital setting is both a concern to parents and an area that is the cause of some difficulty for them and for the staff.

The presence of parents in the pediatric in-patient setting will alter and be altered by the social environment. Skipper and Leonard (1968) studied the effect of experimental social interaction, between the mother of the hospitalized child and the hospital personnel, on the stress level of the child. Results confirmed that when the mother's definition of the situation changed, and her level of stress is reduced, the stress level of the child, as measured by physiological indicators, is also reduced. This study supports the theory of Escalona (1953) that verbal and non-verbal communication of feeling states occurs between a mother and child. This research is also a move toward studying the social environment of the hospital and its effects on parents.

In 1970, Stacey et al., reported the results of a pilot study conducted in pediatric units in England. Their purpose was to study the sociological and psychiatric effects of rooming-in and extended visiting of mothers on the child, the mother, and the hospital setting. The sociological portion of the study was primarily aimed at relating socio-economic status of the family with visiting patterns and defining the factors within the family

system such as siblings and employment that inhibited visiting. They also noted the effect of parents on the social milieu of the hospital and concluded that the extension of visiting hours for mothers, although a step in the right direction toward humanizing care for children in hospitals, also created problems for both mothers and staff that required attention. The presence of mothers was found to constitute a major change in the social structure of the unit. A lack of clarity regarding the role of the mother resulted in uncertainty for mothers and staff. Maternal presence altered the role of the nurse, who, depending on her willingness to allow the mother some share in the work, used her positon of power to restrict visiting and/or control maternal behavior in the setting. Although this study does not provide a detailed analysis of parental behavior in the hospital setting, it does point out the fact that the presence of parents in the pediatric unit does alter the social environment and affect the behavior and roles of the staff.

To date the research and writings about parents of hospitalized children identify various aspects of parental roles and functions in the hospital and briefly describe parent-staff interaction. This literature however is aimed primarily at justifying the presence of parents in pediatrics, and does not provide an in-depth analysis of parental behavior or the social processes involved when parents, as non-professionals who are present in the social milieu of the professional. The research presented here, a study

of parental behavior within the social environment of the hospital setting, is an attempt to add to the existing knowledge regarding parental roles in the hospital and further to formulate a theory, grounded in empirical data, that will explain parental behavior in the social world of the pediatric in-patient setting.

Guiding Perspectives

Although the researcher using field research methodology does not go into the study setting armed with a specific theoretical framework, there are guiding perspectives that serve to direct the investigation. The guiding perspectives for this research were influenced by the already existing theories related to the problem of study and include family dynamics, systems theory, and role theory.

The family is seen as a social system--a set of dynamic interacting and interdependent components (Kantor and Lehr, 1975). The component parts of the family system are the individual members who interact and are interdependent upon each other. No one person can be a family, it is only in relationships to others that a family exists.

The family is considered an open system in that there is an exchange of matter and energy to and from its environment (Hall and Fagen, 1956). Just as a child exists within the totality of the family system, so too, the family maintains relationships with other systems within the larger society such as the school,

government, business law enforcement and church.

All living systems maintain a steady state. This principle of "dynamic equilibrium signifies the capacity for creative, fluid adaptability to change, while at the same time assures that measure of coordinated control that prevents the organism from being overwhelmed..." beyond its capacity to accommodate (Ackerman, 1958, p. 70). There is a certain core of the system, determined by family values and goals, that is constant and yet not resistant to change, shifts, or growth, which expand and add to this core. Input both from within the family and from outside sources serves to either maintain or to alter this steady state.

Every system has a goal or purpose. The main goal of any living system is to maintain itself. The goals of a family are influenced by values held by the system members and are derived from two sources, those relating to society at large, and those emanating from individuals within the family. The former includes the goals of socialization of children and preparing them to assume adult roles, transmitting cultural values, providing for physical, biological, economical and personal needs of the members. The latter refers to needs of the individuals for love, security, support, respect and growth as persons (Rosenstock and Kutner, 1969; Issner, 1972).

The roles of the family members prescribe the behavior expected and specify obligations and rights. For a family to function effectively and maintain stability, these roles must be

complimentary and congruent. All roles have counter-roles, therefore, a change in one role within a complex of interrelated roles, causes an alteration in the related roles (Bell, 1966). Conflict, stress or situations causing a change in the status quo will affect family member roles. Family roles must be dynamic and fluid if the members are to respond to changing input and the possiblities for growth (Robischon, 1969).

Every individual has many roles to enact, albeit there is no set number of roles one individual does or must have. These roles are in part dictated by the positions one occupies. There are expectations and norms surrounding a given position that guide and determine the accepted behavior of a person in that position. Ther term position is used in the literature to refer to a "cognitive organization of role expectations" (Sarbin, 1965, p. 238), or "the location of an actor or class of actors in a system of social relationships" (Gross, Mason and McEachern, 1958, p. 48). A position can be viewed as a static concept. A position with its rights and duties comes alive, so to speak, when an individual in a position acts in a way to put the rights and duties of that position into effect. For example, one can refer to the position of parent with its cognitive expectations and social relationships to others. However, it is the behavior of a person as parent interactng with others that encompasses the role of parent.

Gross, Mason and McEachern (1958) in their review of role theory list three common factors inherent in various role theories:

a role involves social interaction between actor and at least one other; behaviors are exhibited in relation to a given role; and expectations of self and the other exist regarding a given role. According to Sarbin (1954) an individual brings his past experience and socialization to any given social interaction. He is stimulated by the current event through cues, clues and input to formulate a perception of his position and that of the other. The individual actor responds in a manner that is appropriate to the position and role of self and the other. Roles therefore include the self, the individualization process; the other, the interaction process; and society, the socialization process.

Interaction between the individual and society results in the learning of roles, a process labeled as socialization (Brim, 1970). Socialization is not restricted to childhood but occurs throughout life. New encounters, new situations provide the setting for the learning of new roles or for the accommodation of old roles in new situations (Scott, 1970). Human beings do not merely react to each other's actions. A distinctive human characteristic is the ability to interpret or define the other's action and react in terms of that which the situation and behavior of the other symbolizes (Blumer, 1972; Meltzer, 1972). Each situation is uniquely symbolic and is best understood in terms of the individual's perception and definition of that situation. Roles are performed in accord with this situational definition.

For the most part, under normal circumstances people are aware of the expectations regarding their roles. They know how to act and play standard roles according to prescribed social expectations. However, in certain circumstances, such as those dealt with in this study, parental roles are poorly formulated and role expectations lack clarity. Roles are constructed and managed as a result of interaction within a given situation. Therefore, concepts from interactional theory were used to help explain the behavior of parents of hospitalized children.

Since there is no specific well-defined role for parents in the hospital setting, the role of parent-in-the-hospital is one which must be individually determined and managed. The parents in the hospital environment must therefore construct a role that is acceptable to themselves and to others. In this study it is the parent's perception, definition and consequent management of their role in the hospital setting that is of central concern.

Justification for the Study

Ackerman (1958) states, "The family is the basic unit of growth and experience, fulfillment or failure. It is also the basic unit of illness and health" (p. 15). Litman (1974) concurs with this and refers to the family as "perhaps the most important social context within which illness occurs and is resolved" (p. 495). How the family defines illness and the means they utilize to deal with it has an affect on all the members. Family roles are altered when

illness occurs and further altered when a family member is hospitalized. With hospitalization the family system is forced to interact with the hospital system. The interaction of the family as non-professionals, with the health professionals within the hospital setting influences the ability of the family members to re-define their familial role responsibilities and to maintain the family unit. The hospitalization experience of a family member cannot be divorced from the experience of the total family, and as non-professionals the family requires the assistance of the health professional if they are to deal successfully with illness and hospitalization of one of its members.

In 1975, according to a Professional Activity Study (PAS) conducted in 18,087 non-federal, non-psychiatric, short term hospitals, approximately 1,250,000 children between the ages of one month and 12 years were hospitalized during that year (Osborne, 1976). Although advances in medical science have eliminated many childhood illnesses and have provided the means for the prevention of others, the above figure indicates that the number of children hospitalized annually remains substantial. The child, in contrast to the adult, is dependent and immature, making him especially vulnerable and helpless when he is sick and hospitalized. Research has shown that in order to reduce the possibility of trauma for the hospitalized child, it is important that the parents continue in their parenting role to support and care for the child in the hospital in concert with the health professionals.

This study and the resulting theoretical formulation is an attempt to provide a framework that can be utilized by the health professional in clinical practice to identify patterns of parental behavior in order to facilitate parental role management in the pediatric setting and foster family strength and unity. This study also seeks to emphasize factors existing in the social environment of the hospital which affect parent-staff interaction and point out the significance of the position and role of the health professional for parental role determination and enactment.

CHAPTER II

RESEARCH METHODOLOGY: DESIGN AND IMPLEMENTATION

Study Design

The central purpose of this study is to analyze parental role behavior in the in-patient pediatric setting from a holistic comprehensive view, taking into account not only the parents but also the social environment of the hospital. Previous literature and research regarding parents in the hospital setting does little to explain or analyze the behavior of parents, or the social processes involved when parents are present in the pediatric setting. This study attempts to view the parents in interaction with the hospital system and to delineate their consequent patterns of behavior. Key variables in the setting are analyzed to determine the cogency of their influence on parental behavior and to formulate a conceptual model of parental behavior grounded in empirical data.

Field research methodology using the technique of participant observation was selected as the appropriate approach to the study problem. In Social Science, field studies are aimed at discovering the relations and interactions in social settings and are particularly useful in seeking analytic descriptions of complex social organizations (McCall and Simmons, 1969). Field research ranks high among the research strategies used in the social sciences and according to Schatzman and Strauss (1973) allows the researcher to observe events in a natural situation and to listen to the definition of reality

as it is perceived by the individuals who are experiencing the situation. The researcher then correlates what is seen and heard and develops "...an abstract, logical and empirically grounded representation of the observed situation" (Schatzman and Strauss, 1973, p. 13).

Field research seeks to discover and to explain what is rather than to predict as in the testing of hypotheses. The field researcher does not go into the study setting armed with a well devised theoretical framework and specific preconceived hypothesis to be tested. Rather he enters the field with guiding perspectives that direct his beginning observations. He makes no attempt to control the environment but seeks to discover what is occurring in the social world under investigation. The hypotheses thus emerge from the data. This process will be elaborated in the data analysis section of this chapter. Because social settings are ever changing the field researcher seeks to discover the processes inherent in the on-going movement and interactions of the individuals within the setting. It is a search for the basic social processes occurring that explain and account for most of the variations in behavior in the situation under investigation.

In the very early days of searching for a researchable problem statement this investigator conceived of a study using an experimental design. It soon became clear that multifarious variables existed in the hospital setting that could not be controlled but would need to be accounted for. The decision was then made to ask the research question in a way that would foster discovery of these

variables and present them in a manner that would explain the behavior under observation, the extent to, and the conditions under which it occurred.

Human beings do not merely react to each others actions but interpret or define the other's action and react in terms of that which the situation and behavior of the other symbolizes (Blumer, 1972; Meltzer, 1972). It is this individual perspective and definition of the situation that this research attempts to investigate, thereby discovering commonalities and variations that account for patterns and processes of behavior. This study is not directed towards stating specific causes of specific parental behavior, but seeks to clarify the context within which parental response is understandable.

Parents in the hospital setting do not function in a vacuum but seek to define the situation for themselves and then to act based on that situational definition. Although the defining is an intrapersonal process, the person is influenced by input from the surrounding environment. The age and severity of illness of the hospitalized child, the institutional and staff orientation toward parents reflected in rules and policies, and the structure of the work to be done are some of the variables that provide input to the parent. What the parent does with that input and how he/she manages their role under the varying conditions is the central theme of this study.

Qualitative or field research entails a process of discovery. This discovery aspect is both exciting and filled with weighty

responsibility for the researcher. The excitement lies in being able to describe, explain, analyze and conceptualize common occurrences in a way that is understandable to those who have experienced these occurrences and yet adds new insights and a greater depth and breadth of comprehension. The responsibility lies in the commitment of the researcher to ground the analysis and the emergent theory in empirical data. The researcher must find that which is central to the persons under observation. To do so he must "take the role of the other" so as to view the scene through their eyes rather than impose his own meanings on the situation and thereby ensure validity and credibility of the research findings. Field research provides the scientific framework within which the researcher interacts with the subjects of study to learn their meanings of the situation. He then analytically describes the situation in a manner that represents the participants in their own terms (Lofland, 1971).

Participant Observation and the Researcher

There is a relative freedom of exploration in field research and participant observation within the boundaries of scientific inquiry and methodological procedure. McCall and Simmons (1969) describe participant observation as a blend and combination of a variety of techniques which include: social interaction of the researcher with the subjects of study, observation of relevant situations, formal and informal interviewing, document review and an open-minded attitude about the direction the study takes.

Pearsall (1965) describes a continuum in participant observation from complete observer, to participant-as-observer, to observer-as-participant, to complete participant. The positions at either end of this continuum are questionable with respect to the rights of human subjects in that the identity and purpose of the researcher is not made known. These roles were also seen as too limiting to the researcher: one in terms of the type of data that could be collected, being mainly restricted to observation; the other in terms of excessive immersion in the situation and the tendency to lose the objectivity so necessary to the research endeavor, as well as restrictions placed on the use of one's time and the freedom to explore relevant situations.

This researcher defined her role in the participant-as-observer to observer-as-participant range and functioned by shifting between these two positions. The identity and purpose of the researcher was made known to the staff and to the parents. At times the researcher was more the observer or outsider remaining on the fringes of a situation. At other times situations were penetrated more deeply and the researcher interacted with the individuals in the setting in order to collect data bearing on personal meaning, to cross-check information and to verify the observations. The procedures and techniques used during this investigation will be detailed in the data collection section of this chapter.

The Nurse Researcher Vis-A-Vis The Nurse Clinician

As this study deals with the concept of situational role management, it was not unusual that this investigator also focused on the management of her role as a nurse researcher compared with that of a nurse clinician. This role transition was in fact a source of interest, and at times concern, throughout the research process.

This investigator's prior career as a nurse clinician was no doubt influential in gaining entry to the study settings and acceptance from the staff. Knowledge of what occurs on a pediatric unit allowed the researcher to pace and space her presence so as not to inerfere with the delivery of patient care. However, because this investigator had worked in two of the settings and therefore had a history and biography as a nurse clinician, but was being introduced as a nurse who was doing research in all the settings, the role of a nurse researcher had to be clarified and defined both for herself and for the staff.

Working as a nurse clinician, this investigator had actively performed functions that visibly contributed to patient care both directly and indirectly. The nurse researcher role had both a passive aspect, observing, and an active one, interviewing and questioning, but there was no visible contribution to patient care. This doing orientation of the nurse clinician was reflected in initial questions of the staff, "What will you do?", "What are you going to do today?" These questions provided the opportunity to state the doing

of the researcher involved observation and some interviewing, that she was not there to do in the clinical sense of the word but to observe, reflect on, and try to understand what was being done.

Further clarification of the nurse researcher role came as a result of requests made by the staff, "Will you see Mrs. X she really needs someone to talk with and to support her?" Olesen and Whittaker (1967) refer to this as the "proferring and inviting phase" of role making in participant observation. In this phase the parties involved attempt to "...expand the meanings of their own roles and the roles of the other" (Olesen and Whittaker, 1967, p. 275). This type of request presented an opportunity to delineate the boundaries of the nurse researcher role. This was done by acknowledging and commending the staff's concern for the parent, but pointing out that this was in fact not a function of the nurse researcher role. Further it was believed that support should come from the staff members with whom the parent would then build up a rapport and who would be there on a consistent basis to provide continuing support. These opportunities were then used to discuss with the staff their perspective regarding the time available to them to devote to handling parent problems and what they saw as parent needs.

At the same time it was not easy to refuse this type of request to assist the staff. The requested service was within the capabilities of the researcher and the satisfaction gained from such

encounters appealed to her own original clinician orientation. It was an opportunity to legitimize the role of a nurse clinician which was more highly valued and more easily grasped by the staff. Self esteem is enhanced through the adequate performance of a role. This investigator was new to the role of nurse researcher and somewhat unsure and uncertain of it. However, the need to maintain clarity of that role both for the staff and for herself was of paramount importance, and could be easily jeopardized by allowing an undue amount of direct involvement in the work of the staff. On occassion, telephones were answered in the setting and messages given and received for the staff, but for the most part this investigator assumed a stance of non-interference with the on-going activity except to ask questions to clarify and give meaning to observations. As a result, the role of nurse researcher was gradually understood and accepted by the staff. Their requests for assistance changed to suggestions regarding which parents might be willing or appropriate to participate in the study, or informing the investigator of situations that had occurred or were about to occur that might prove interesting and of benefit to the study.

This transition to adequate performance in the role of a nurse researcher in a clinical setting proved to be both a vital learning experience and a self-enhancing process. The essence of this transition involved a change in attitude, or has more appropriately been termed, "posture." The nurse researcher functions within the

arena of scientific inquiry. The scientific approach, or research posture, is a special systematized form of reflective thinking and inquiry, the aim of which is to explain natural phenomena, to make discoveries and learn facts that serve to advance knowledge. The clinical "posture," on the other hand, aims at producing change that will result in improvement in individual patients, with the primary focus on the health-illness continuum of the individual.

Sheldon (1963) aptly describes some of the differences between the nurse clinician and the nurse researcher. The nurse clinician is service oriented and pragmatic. Her aim is to achieve practical goals with her patient. She is time-bound and structured with much of her day being routinized and taken for granted. She is action oriented, involving herself in the situation and concentrating on aspects that can be manipulated. The nurse clinician views each patient as an individual and evaluates her actions based on what is the most productive or beneficial for the patient. The nurse researcher on the other hand, is oriented toward the search for knowledge, the facts that will explain everyday occurrences. She maintains an attitude of relative objectivity that is essential to scientific inquiry and the discovery of true facts and meanings. She seeks to separate herself from what is being observed and employs a methodological process and procedures. Although she cannot help but experience subjective feelings regarding what is observed or encountered, these feelings are acknowledged

and analyzed as another piece of data and part of the research process. She is not time-bound but moves freely within situations that are relevant to her area of inquiry.

The nurse researcher using field methodology and a sociological approach studies social structures and social processes. She views persons not only as individuals but as members of groups having a cultural background, positions, and roles within the environment. Her emphasis is on social organization and the processes of interpersonal relationships and interaction. She does not moralize and evaluate occurrences but describes, analyzes and explains the natural empirical phenomenon occurring. In observing situations she asks questions such as: What is going on? Who is involved? What does it mean? What affect does this situation have on the persons involved and the context within which they are interacting? She then aims to formulate general principles which explain certain features of social life and develops abstract conceptual schemes that have empirical validity. She attempts to give meaning, based on empirical data, to everyday occurrences.

Clinical nursing research has the added dimension of applicability to patient care. It is a search for knowledge that will explain and verify, with the ultimate goal of improvement in patient care. This improvement or change in patient care, however, is the long-term goal of the finished product, not the immediate result of the daily activities of the researcher.

This transition from nurse clinician to nurse researcher is not an easy task, especially if one has a lengthy history as

a clinician. Attitudes taken for granted come to the fore and need to be examined. In fact, part of this research process consisted in making a concerted effort to refrain from viewing and judging a situation in relation to its immediate value to the patient, but to see it in light of the social processes involved and the overall emerging theory.

Negotiating Entry

Initial Entry Process

Prior to beginning the study the proposed activities of the researcher were made known and access to the study setting negotiated. Although the initial entry is but the first step in a long line of research activities, considerable attention is given to planning the entry strategies. Previous experience in hospital settings served to increase awareness of the existing hierarchical structure, the importance of approaching key individuals who act as "gate-keepers" in order to gain sanction and access, and the advisability of starting at the top of the hierarchical structure and working down. The position of researcher is that of a guest in the host institution and it is therefore important not only to gain admission but to keep individuals in the institution informed of on-going research activities. Previous clinical and academic nursing experience of this researcher in the area of pediatric and family nursing, and prior employment in two of the study settings were recognized as factors facilitating the process of entry negotiation.

The in-patient pediatric units of three general hospitals were used as study settings for this research. Selection and description of these settings is detailed in the following chapter. The first step in gaining access to the pediatric units was to contact the Medical Chief of Pediatrics and the Director of Nursing Service at each of the hospitals, thus touching base with medicine, nursing and hospital management. In one hospital the Director of Nursing suggested that initial contact be made with the Assistant Director of Nursing Education and this was done. These individuals were designated as the gate-keepers of the institution. The purpose of these contacts was to present the research proposal and to negotiate entry to the pediatric unit. A copy of the research proposal was sent to the individual to read and an appointment followed during which time the study was discussed in greater detail and points of concern clarified.

All of the contacted individuals were enthusiastic and supportive of the need for the study. Some concerns arose from the confusion between field research methodology and experimental research with regard to sampling of subjects. Theoretical sampling based on theory emerging from the data was explained in contrast to the random sampling procedure of experimental research where every person within a population has the same chance of being selected to participate. The rights of both parents and staff were discussed at length, that is, their right to refuse to participate and their right to confidentiality if they did participate. Another concern voiced was the ability of some of the parent subjects to read

and understand the consent form. Assurances were given that every attempt would be made to see that each individual giving his/her consent had a clear idea about the study and understood their right either to refuse to participate or to terminate participation at any time. Due consideration was given to these concerns with the result that no problems related to them occurred during the time of data collection.

Reciprocity in terms of feedback to the staff at the completion of the study was also discussed. One of the purposes of this study is to ultimately benefit health professionals working with hospitalized children and their families. Also the staff would be giving their time and energy to participate in the study and to assist the researcher. Therefore, this responsibility of providing feedback was one that was gladly accepted. It was stated, however, that there was no intention to evaluate or moralize about the observed activities, and that any determined need for change would come from individual interpretation of the presented findings. Originally it was anticipated that feedback could be given at the end of the time spent in each of the settings. However, the analysis of findings at that time proved to be in preliminary and evolving stages. The decision was then made to share the study findings at the completion of the analysis.

Letters of approval and support of the study were written by each of the Heads of the Pediatric Departments, the Directors of Nursing, and the Assistant Director of Nursing Education.

Final endorsement of all the individuals was contingent upon consent of the Head Nurse of the pediatric unit. Meetings were then set up with the Head Nurses. They were given a copy of the proposal and the study, the researchers activities and the amount of staff involvement was discussed. They all enthusiastically supported the study and sanctioned entry.

Entry negotiations at the private hospital entailed two additional steps. First, it was required that the research proposal be sent to the Research Committee of that institution. Approval was granted with recommendations for slight changes in the consent form. These included having the name of that hospital appear at the head of the form along with that of the University under whose eagis the study was being conducted, and a line inserted for the signee to designate his/her relationship to the child. These changes were made in the form that was used at that hospital. Second, the Monthly Pediatric Staff Meeting was attended and the research proposal presented to the Physicians. They were supportive of the study and requested only that they be informed individually when a parent of one of their patients was interviewed. This was agreed to and done either in writing or by phone.

Secondary Entry Process

Schwartz and Schwartz (1969) view the entry process as a continuous one of negotiation with each person encountered, and one based on evolving and changing relationships of the researcher and the individuals in the setting. After gaining permission to utilize

the pediatric facility from top and middle management in the settings, a separate letter was sent to the nursing staff on the units one week prior to my arrival. This letter introduced the researcher, explained the purpose of the study and anticipated activities of the researcher and requested the assistance of the staff. The majority of the staff had read this letter and it proved helpful in the verbal presentation of self to the staff.

The first week in each of the settings was devoted to meeting the nursing staff on all shifts. This researcher was familiar to soem of the nursing staff and with these individuals it was a matter of re-establishing a relationship and defining the current role. With others unfamiliar to the researcher it was a matter of introduction, statement of purpose and role clarification. The meetings lasted approximately fifteen minutes. Background of the researcher and the concerns that led to the current study were discussed. The study was explained and ample opportunity was given for questions to be asked. The right of individual staff members to refuse to be interviewed was discussed. Confidentiality of the interview information was stressed, as well as the flexibility of the researcher as to time and length of interview depending on the availability of time for the staff. These initial meetings varied but in all meetings questions were asked regarding method and sample, and purpose of the study. The majority of the staff were verbally enthusiastic and supportive. They shared some of their concerns about parents and expressed anticipation of study findings and the possible benefit to them and their work with

parents of hospitalized children. Staff support continued throughout the time spent at the settings in terms of their willingness to grant interview time and answer the many questions of the researcher, and in making suggestions of possible parent subjects and frequent inquiry as to the progress of the study.

Once in the setting the Chief Pediatric Resident was contacted and the study and role of the researcher explained to him. A request was made to relay this information to the other house officers. In some cases this information was disseminated among the house officers, in others individual contact with a house officer necessitated a statement of role and explanation of the study. This was necessary to gain entry to house officer-parent-patient situations such as history taking, treatments and procedure, and also to be included in house officers patient rounds and to ask questions and do informal interviews. At no time was the researcher's presence to these situations restricted.

Negotiations and entry with parents involved the presentation of self as a nurse in a doctoral program doing research. An explanation of the study and its purpose was given. Emphasis was placed on personal use of data and anonymity of the parents who did choose to participate, and the individual parent's right to refuse observation or interviewing.

On the whole, entry at all levels was relatively easily managed and successful. Prior work experience at two of the settings and a background of experience as a pediatric nurse are recognized as being influential in this process. Questions were asked by all

the individuals encountered and attempts were made by these persons to clarify the role and purpose of this investigator. The researcher did not perceive herself as a threat to the staff or parents in the setting and there was little indication overall that she was viewed as such. The exception to this was the nursing assistants or aides, a few of whom were somewhat wary of the observations made of them. This initial response lessened with the continual presence of the researcher.

Presentation of Self

The presentation of self in all instances was that of a nurse, in the Doctor of Nursing Science Program who was doing a research study. No attempt was made to conceal the investigator's identity either as a nurse or as a researcher. In fact, part of the explanation given to parents in the setting was that the information gathered would assist both the investigator and other nurses in working with parents of hospitalized children.

Street clothes were worn by the researcher. This was done so that parents would not infer direct association of the researcher with the nursing staff of the particular hospital and thereby hesitate to give certain information, especially that of a negative nature. Another purpose of this attire was to deter them from requesting patient services that were not considered to be a part of the role of the researcher.

The decision to wear neither a uniform or a lab coat was also felt to be relevant for interactions with the nursing staff. In

the hospital settings lab coats are frequently worn by persons in administration. These persons are in positions of authority and by virtue of these positions can be threatening to the staff. Neither an alignment with such factors in the setting nor a stance of authority was desired or seen as beneficial. Gussow (1964) sees "observation as a relationship" in which the observer and observed are involved in interaction and each influences the other. Schwartz and Schwartz (1969) refer to the process of "mutual habitation" that occurs between the observer and the observed. The intention of this researcher was to facilitate this type of "mutual habitation" as quickly as possible and present a self that would be as minimally threatening as possible.

Another aspect of presentation of self considered extremely important was that of a neutral observer. The definition of self as neutral observer became important in this secondary entry process. Jackson (1975) states that nursing staff are not accustomed to being observed and usually label any observation as evaluatory. Several remarks were made and questions asked by the staff that alluded to a concern that the researcher was in an evaluative role. On each occassion when this occured the researcher took great pains to verbally correct this notion. She was also acutely aware of attempting a neutral stance in non-verbal behavior when observing, in the choice of words used when questioning and talking with the staff, and in her responses to comments made by the staff.

Data Collection and Analysis

In the research methodology selected for this study data collection and analysis occur concurrently in a continuous process of discovery. Since this method promotes the discovery of theory rather than the separate testing of hypotheses and analyzing of results, data collection, coding and analysis form a combined unit of the research endeavor. Although the field researcher enters the field with some motions and tentative hypotheses which provide direction to activiites and observation, these may be soon discarded in the face of the reality observed. As the data are collected the researcher reflects on the data and analyzes it to determine its relevancy within some beginning organizing scheme and starts to formulate categories and concepts upon which to build. These conceptualizations determine the collection of further data.

Using the grounded theory approach of Glaser and Strauss (1967) the theory emerges from the data and leads to further data collection (theoretical sampling) in order to compare (constant comparative analysis) verify, explain or delimit the emerging theory. The various concurrent processes of this research enterprise will be separated here for clarity and ease of presentation.

Data Collection

Sources

Data for this study analysis is based on 22 interviews with parents of hospitalized children, 23 interviews with pediatric

nursing staff, 10 interviews with other health professionals in the setting, and approximately 180 hours of observations on all days of the week and all shifts in three pediatric units. Data collection spanned a period of six months from July 1976 through December 1976. Approximately six weeks was spent in each of the three settings with interruptions in this process for intensive data analysis. The settings were visited sequentially in order for the researcher to immerse herself in the ambiance of the particular setting.

The first study setting was determined by the fact that one of the pediatric units anticipated a move to a new facility. This site was selected first in hopes that data collection could be completed prior to the move. Only four weeks had been spent in the setting when the moving date was set for the near future. During that time observations had been done and several staff interviews conducted but no English speaking parents of children of the designated study age had been contacted.

Due to the imminence of the move the decision was made to leave the site, move on to another and return a month after the move. This decision was based on the fact that the closer the time to the move the more preoccupied the staff would be with it. Also a period of adjustment after the move was needed so that staff would have become acclimated to the new physical environment. Observations and interviews after the move verified the fact that the new environment did not change patient census or the type of patients admitted. Staffing patterns remained the same and no

significant change was seen to occur in the patterns of parent-staff interaction.

In advance of collecting data the boundaries of the study universe were defined. Certain specifications were placed on the parent population to be interviewed. The parents had to be English speaking. The researcher did not speak any other language and did not choose to utilize the services of an interpreter. Both mothers and fathers were included as subjects in the study. Previous studies focused mainly on mothers in the hospital setting. The focus of this study however was parents and therefore included both. Only biological parents were interviewed, thus eliminating step or foster parents. No limitation was placed on the socio-economic level of the parents. It should be noted here that this study deals with parents who were present to some extent with their child while that child was hospitalized. No data was collected on parents who did not visit their child in the hospital, and therefore any attempt to explain such behavior would be conjecture on the part of the researcher and not grounded in the data.

The hospitalized child was between eighteen months and four years of age in order to maintain consistency within a stage of growth and development, and also because it was thought that parents of these young children would more likely be spending time in the setting. Scheduled and non-scheduled admissions of either medical or surgical conditions were included. Families of children with terminal illness who were in imminent danger of death or families of battered children were not included as these cases

are believed to invoke family reactions and behaviros that are specific to those conditions. The length of the child's hospitalization was from three days to two weeks. This time span eliminated overnight and short stays that necessitate only limited interaction between the family system and the hospital system and also eliminated extended stays.

Demographic data was collected on all the parents who were interviewed. Ethnicity of the parents included 13 Caucasian, three Black, three Filipino and two Spanish-American. This approximated the ethnic breakdwon of the setting populations. The ages of the parents ranged from 24 to 65 years, with the average being 30 years of age. Educational background varied. Two parents had completed tenth grade, eight completed high school, eight had between one to three years of Junior College and four had graduate degrees. Socio-economic status ranged from upper lower to upper middle class and was determined through data on employment and income. Some of the parents were not gainfully employed, such as housewives, while others were temporarily out of work. Occupations of those employed included manual labor and blue collar workers, clerical and management positions, and small private business owners. Family composition varied with 40% having only one child, 40% having two to four children, and 20% having five or more children. Eleven of the families lived within the city; four in nearby surrounding areas, and seven were from distances greater than 60 miles. Six fathers and sixteen mothers were interviewed.

The ages of the hospitalized child were eighteen months through four years. Fifty percent were in the hospital for the first time, 20% were in for their second admission and 30% had been admitted three or more times. This varied selection was the result of theoretical sampling based on emerging hypotheses in the analysis of the data. Illness conditions included: acute admissions such as meningitis, kidney failure, asthma; scheduled surgical admission for hypospadius and tendon repair; and chronic illness such as leukemia, Wilms tumor, spinal bifida, and nephritis. All of the children had been hospitalized between four days to two weeks at the time the parents were interviewed.

Of the nursing staff interviewed twenty were registered nurses, two were nursing aides, and one was a licensed vocational nurse. Three of the registered nurses were head nurses, one a clinical specialist, and the rest were staff nurses from the day, evening and night shifts. The length of employment spanned one to fourteen years with the average being five years. Educational background of those interviewed included Doctor of Nursing Science, Masters in Nursing, Bachelors in Nursing, Diploma graduates and graduates with an Associate in Arts degree. Interviews with other health professionals in the settings included those with two chief residents, one resident, two interns, two social workers, and two recreational therapists.

Part of the data for this study came from interviews, and part from observation. The observational aspects of data collection are dealt with in the following section.

Observation

Participant observation allows the researcher to interact with the participants of the study in their natural setting in order to gather data about how they understand and view what is going on. The researcher herself is the instrument used to gather data and it is therefore crucial that strict adherence be paid to the accurate recording of the reality that is observed.

Prior experience in a pediatric setting and familiarity with regard to what goes on from a clinical view point was an important consideration for this investigator. One can become dulled to what are considered natural or expected phenomena. It was important therefore for this researcher to look at what was occuring with different eyes, so to speak. The relevance of what was observed needed to be examined in light of the emerging organizing scheme and concepts rather than in terms of efficiency or productiveness for patient care. Rather than assuming what was meant, attention was given to clarification by the participant in light of his/her perception. Questions of meaning to the participants and consequences for their behavior became the focus of observations.

The mere presence of an observer, an outsider looking on so to speak, has an impact on the individuals in a setting. Reactions to an observer can vary from extreme caution and guarded behavior, to acceptance of the observer and a display of normal activities and patterns. The observer herself can feel out of place, uncomfort-

able or uncertain of her role and behavior. The manner in which the observer conducts herself and how she relates and interacts with the participants in the setting will determine to a large extent the outcome of her continuing presence.

This researcher was aware of the need to tread lightly into the territory of the other and to maintain an attitude of respect, empathy and human-ness. The initial time in each of the settings therefore, was spent getting to know the nursing staff and allowing them to become accustomed to the presence of the researcher as a familiar non-threatening figure. The activities and observations of the researcher were low keyed at first, remaining on the periphery and slowly moving into situations based on her assessment of the readiness of the staff. Questions and informal conversations with the staff conveyed an attitude of respect and acceptance of their feelings and the meanings they attributed to situations. With time it became clear to the staff that the researcher was not there to evaluate or make judgments regarding their activities or to interfere with patient care but was attempting to understand, and did give credence to their interpretations and comments. Also, the stated general nature of inquiry, that is, parents of the hospitalized child, gave little indication to the staff as to the specific focus of what was being sought. This fact along with the requirements and priorities of their work day made it less feasible for the staff to be canstantly on their guard. The result was that comments and behavior were with time more open and natural.

Some time was spent observing on all three shifts to get an overall perspective of the interactions and behavior occurring over a twenty-four hour period. A variety of sitations were observed and included; patient admissions and discharges, staff conferences, reports, rounds and meetings, patient treatments and procedures, history taking sessions with parents, routine activities such as bathing and play, parent meetings and informal parent get togethers. Opportunities such as coffee breaks and meals with staff or parents were also used as sources of data.

Initially the fear existed that everything had to be observed and nothing should be missed. It soon became evident that this is physically and psychologically impossible, as well as theoretically unproductive. Thus, in the beginning observations were made and dutifully recorded although many of these seemed disconnected and random. However as the study progressed these observations were increasingly directed by the dominant patterns emerging in the data analysis and by the need to further validate tentative hypothesis and concepts.

Theoretical Sampling

The process of theoretical sampling is inherent in the grounded theory approach to data collection and analysis in order to generate theory. According to Glaser and Strauss (1967) theoretical sampling gives a direction to data collection that is controlled by the emerging theory. The researcher makes a decision regarding where to begin. Once the initial data is collected analysis begins,

questions arise, categories begin to emerge, and the theory is being formulated based on the data. This in turn leads to further data collection using the criteria of "...theoretical purpose and relevance not of structural circumstance" (Glaser and Strauss, 1967, p. 48). For example several of the first parent interviews were conducted with parents of chronically ill children. Questions begin to arise regarding possible similarities and differences between parents of the chronically ill child and parents who's child was acutely ill and hospitalized for the first time. As a result a concerted effort was made to contact and interview parents of acutely ill children. This did prove analytically relevant to the emerging theory. The use of theoretical sampling was also responsible for interviews done with other health professionals in the setting, such as house officers, social workers and recreational therapists as it became clear that they were to some degree influential factors affecting parental behavior and response.

Interviews

No set pattern of observation and interviewing was followed. That is, observation at times preceded interviewing or vice versa. A semi-structured open-ended format was used in the interviews in order to maximize the opportunity for the interviewee to discuss matters deemed relevant to them. The researcher did alter the emphasis of the interviews somewhat as time went on to allow for more in-depth probing of material relative to the emerging analytic patterns and concepts.

Prior to any interview a consent form was read and signed granting permission for the interview and the use of a tape recorder. Tape recording freed the researcher from the distraction of note-taking and allowed her to concentrate on both verbal and non-verbal clues from the interviewee. Also voice nuances and pertinent expressions were preserved to be considered in the analysis of the interview data.

Although most of the interviewees were somewhat hesitant about the tape recorder, this apprehension lessened quickly as the interview progressed. There were a few occasions when the tape recorder was not used. At these times either verbal or non-verbal indications were given by the interviewee that they were particularly uncomfortable and felt hindered being recroded. At these times notations were made of key phrases and comments of the interviewee and the details filled in at a later time.

All individuals approached were afforded the opportunity to refuse to be interviewed. Of those approached one parent and one staff member refused to participate. The parent was a nurse and was from out of state. She was interested in the study and spoke to the researcher on several occasions in an informal manner but did not wish to participate in a more formal interview. The staff person was a nursing assistant who appeared to be threatened by any type of formal interview process. In both instances this right to refuse the interview was respected. However, the case of the nursing assistant afforded the researcher the opportunity to reflect on the approach needed with nursing staff. The nursing

staff voiced more concern prior to interview regarding their ability to give the "right" answers. They were assured that there were no right or wrong answers and that it was their own personal perceptions, meanings and feelings that were relevant and would contribute to the study.

Interviews with parents lasted from one to one and a half hours, those with staff from fifteen minutes to an half hour. Some of the interviews were conducted in two segments because of the time factor, and occasionally the interviewee was approached in the days following the initial interview for further questions or clarification. Times of the interview were left to the discretion of the interviewee. Interviews were conducted in the hospital setting in a room that afforded the necessary privacy.

Each interviewee was informed of the coding procedure used to protect their anonymity. They were also assured of confidentiality in that the information received was for the personal use of the researcher and that no information identifying a specific individual would be shared with other parents, staff, individuals or institutions. This latter assurance served to facilitate the relating of negative comments and feelings without the fear of reprisal. Ther persons interviewed indicated faith in this assurance of confidentiality. At no time was the researcher questioned regarding information received from other individuals, despite the fact that the staff for instance, were aware on many occasions of which parents were being interviewed.

A neutral, non-judgemental and friendly attitude was maintained by the researcher during the interviews and every attempt was made to minimize stress on the part of the person being interviewed. At the close of most of the interviews comments were made by the interviewee that they had enjoyed the interview and that it was not as difficult as they had anticipated. Parents were especially appreciative of having the opportunity to express their feelings and relate their experience.

Recording

Observational notes for this research were recorded using the scheme suggested by Schatzman and Strauss (1973). According to this method recording is divided into: observational notes (ON) containing the raw data, that is what was observed; methodological notes (MN) comments regarding effectiveness of techniques used and directions for further research strategies; and theoretical notes (TN) interpretation and inferences regarding the data and beginning conceptualizations.

Recording of observations was done both in the setting or as soon as possible after leaving the setting. While in the setting brief phrases and comments were jotted down as inconspicuously as possible. Then at a later time these were used to re-create the situation observed with its perceptual and feeling dimensions. Interviews were transcribed from the tapes as soon as possible. Three copies of each interview were made. One to be kept in its origian form, the other two to be used for coding and analysis.

Termination

Just as the entry process involved specific strategies on the part of the researcher, so too did the exit or termination process. When the data collection was completed in a setting the head nurse was verbally informed. Also a letter was sent to the staff, with copies to the Nursing Director and the Chief of Pediatrics. The letter expressed appreciation for being allowed to conduct the study on the pediatric unit, and for the time, assistance and involvement of the staff. The letter further re-affirmed the commitment of the researcher to share the study findings with the staff.

Data Analysis

The analytical method used for this qualitative research was that of constant comparative analysis as proposed by Glaser and Strauss (1967). As the term implies this type of analysis is constant, beginning with the collection of data and continuing through the research process. Its purpose is to compare and contrast data so as to generate conceptual categories and dimensions that will eventually be used as the building blocks of the grounded theory.

The researcher interacts not only with the participants in the setting but also interacts with the data itself. This analytical interaction is not accomplished in a random or haphazard manner but is systematic and organized. The generating of grounded theory is a developmental process which includes the steps of

conceptual category generation, integration of categories and dimensions, reduction and delimitation of categories so that relevant theoretical categories are selected formin a dense interrelated web of theory, and finally writing the theory (Glaser and Strauss, 1967).

The formulated theory is grounded, that is based on empirical data, there is therefore a constant comparison among data, among conceptual categories, and between the emergent categories and back to the data. This constant return to data safeguards the researcher from making quantum leaps to explain the data, or from attempting to force-fit data, and therefore grounds the theory in empirical reality.

The focus of this research was to generate a substantive theory. Substantive theory seeks to elucidate a specific area of social inquiry, in contrast to a formal theory which is developed for a conceptual area. Parental behavior in the in-patient pediatric setting is the substantive area of this research and therefore the analysis of data involved comparison between and among groups within that substantive area. Among the comparative groups in this study were: parents of acutely ill children versus parents of chronically ill children, parents rooming-in versus parents who visit, parents versus staff, and parenting versus medical work.

According to the constant comparative method, similar groups are compared in order to high-light the basic properties and

dimensions of categories, and to maximize similarities, differences and variations. Categories are modified and broadened in order to clarify the boundaries of applicability of the theory and to increase its explanatory power. The specific operations of this analytical method are described in the following sections.

Category generation and integration

As the researcher begins to collect data there is a tendency to feel inundated with a multitude of heterogeneous facts. In order to make some sense of these facts the process of open coding is begun. coding is done off the raw data and represents substantive and theoretical abstractions of that data. The codes are not merely descriptive, such as age, sex or numbers of persons, but are conceptual abstractions of the processes and behaviors that are being observed.

The research strategy of coding involves a process of taking the data apart and re-assembling it to form hypotheses and categories. The first step in this process is finding substantive codes. These are words or phrases actually used by the participants in the setting, the meanings they give to their behavior. Some examples from this study are, "being with," "watching over," "looking for the look," "doing what they say." These codes are written in the margins of the data to indicate where the process occurred. Other substantive codes are constructed by the researcher to explain and conceptualize the processes observed, for example, accessibility, information giving, territoriality. Substantive

codes are the beginning conceptualizations of the processes occurring in the setting and will form the building block of categories and the emerging theory. Substantive codes are then related and linked to others from the data until sets or classes of things are found that form categories (Schatzman and Strauss, 1973).

Theoretical codes are means by which the various substantive codes are ordered and interrelated, and the dimensions of categories are determined. Some theoretical codes include: conditions, strategies and tactics, consequences, "cross-cuttings," and phases. Theoretical codes must also emerge from the data. For instance at one point the emphasis will be on conditions and consequences, at another strategies will predominate. In any case the theoretical codes must be based on the reality of the empirical world.

As categories emerge they are constantly compared with and related to other categories from the data. Through this process the dimensions and properties, that is the parameters and structural characteristics of the categories, are elaborated and ordered.

The following example from this study is given in order to illustrate this process of coding for the purpose of generating categories. Initial observation of parents in the hospital setting revealed the parent's hesitance on the whole to interfere with the work of the staff and to conform to the staff's control in many situations. Comments made by parents in interviews relating to this hesitancy or conformity were substantive codes such as, "not interfering," "doing what they say," "staff are the 'power

brokers'." Parent interviews also brought out the dimension of perceived threat by the parents to the care of the child if they interfered. This dimension was abstracted and coded as "threat: risk/benefit." Observations of staff-parent interactions regarding the presence of parents during the performance of medical procedures on the child revealed situations in which parental behavior was influenced or controlled by the staff. These situations were coded as "Inclusion/exclusion: staff control." All of these substantive codes became dimensions and properties of the key category of balance of power. They were further used to construct the theoretical codes of strategies and consequences with regard to the negotiating processes utilized by parents in order to tip the balance of power and gain control.

Delimitation - Reduction - Saturation

It soon becomes evident to the researcher that she cannot hope to cover the entire scope of multiavriant processes in any given social world. Of the categories gleaned from the data those that are deemed most relevant to the emerging theoretical scheme are pursued, other are dropped or relegated to a place of minor significance, thus delimiting the number of felevant categories.

Still further, categories become subsumed or reduced under other categories in order to build higher level concepts and more clearly formulate the theory. For example, the categories of threat: risk benefit and types of power were subsumed under the category of balance of power; medical work, division of labor, and ward work

became dimensions of the category of work structure.

Data is collected that bears on the various categories until saturation ensues. Theoretical saturation occurs when despite the use of theoretical sampling nothing new emerges that aids in the explanation of the theory (Glaser and Strauss, 1967). This is not to imply that the entire filed or setting has been exhausted of experience or of data, only that for the present theoretical scheme saturation has occurred.

The Core Category

As the key or major categories are compared, ordered, delimited and reduced, the core category of the study emerges. This core category is the basic social process that has emerged from the data and is the central idea that holds the study together. The core category is that which explains or accounts for most of the variation in the data and is related to more variables than any other.

The core category that emerged in this study was determined by this researcher to account for the majority of variations in parental behavior in the in-patient pediatric setting. Once discovered, the data were re-examined to verify the fit with this core category, and to guard against premature foreclosure regarding the core category. In addition, sections of data were shared with nurses and sociologists. They concurred that the selected core category was explanatory and centrally pertinent to the problem under study.

Memo Writing

As categories emerge and are linked with other categories, and properties of categories are compared, theoretical implications are formulated. Ideas occur to the researcher that are of an analytical nature. Categories are related and dimensions and cross-cuttings are discovered. In order to capture these ideas, analytical memos are written. Analytical memos are a combination and extension of the theoretical memos written earlier in the coding process. These memos can vary in length from one paragraph to several pages. As with everything in the analytic process these ideas are sparked by and grounded in the data. Memos are linked and compared with other memos. They are re-worked and re-formulated in order to constantly build the conceptual scheme of the analysis. Memo writing assists the researcher to organize her thoughts and is vital to the final formulation and writing of the theory.

Writing the Theory

In putting pen to paper and writing the theory this writer has attempted to provide a clear and logical presentation of the grounded theory and the data from which this theory emerged. Incidents from the data are interwoven into the written account in the service of rendering the analysis meaningful and understandable, and to allow the reader to enter with the researcher into the world of parents of hospitalized children. Data and its analysis are presented in an integrated manner so that the theory

emerges on paper as it did in the actual collection and analysis of the data. It should be noted here that this researcher does not purport to say that the proposed analysis is the only one possible given the data collected. It is however hoped that what is presented is done in a manner that will convey plausability and credibility of the proposed analytic framework and theory.

Credibility of Qualitative Research

Glaser and Strauss (1966) state that the criteria for judging the credibility of qualitative research should be based on the generic elements of this research methodology, rather than on the applicability of the canons of quantitative research. According to these authors the credibility of qualitative research rests on the following criteria. First, evidence of the researcher's adherence to the processes of joint collection, coding and analysis of data, and use of theoretical sampling and the constant comparative analysis of the data. Second, the trust and conviction of the researcher in the analytic framework proposed, which is the result not only of his having been there in the field, but of careful scrutiny and verification of hypothesis and a "gut-level" belief in the final analysis. Third, the analytic framework should be presented in a manner that affords the reader the opportunity to make his own independent judgments as to its credibility and veracity.

In the following chapters this writer has attempted to present the analytic framework discovered in a clear and logical format

of interrelated categories, and to describe the social world of parents in the hospital setting in a way that will take the reader there, so to speak, and allow him to see and hear what occurred and to do so in relation to the proposed analytic framework and emergent theory.

CHAPTER III

STUDY SETTINGS AND THE HOSPITAL SITUATION

The purpose of this chapter is two-fold. First to present the bases for the decision regarding the selection of the study settings and to describe in detail each of the settings; and second, to focus on the hospital situation within which parents manage their roles. The first section deals with the study settings and the second with the hospital situation.

Section I

Study Setting Selection

Once having established the research focus of interest the researcher must then select a site or sites that contain the persons and social activity bearing on that interest (Schatzman and Strauss, 1973). This study was conducted in the pediatric in-patient units of three general hospitals within a large metropolitan city, a university hospital, a county hospital, and a private hospital. Three settings were selected for this study in order to broaden the data base, facilitate analysis of similarities and differences among conditions within the setting and among parents in different settings, and increase the generalizability of the study findings. Neither the hospital or the pediatric units were viewed in terms of the quality or efficiency of the

patient care given. Rather, variations in existing conditions are analyzed and related to patterns of social behavior and processes within the settings.

Other considerations in the selection of the specific settings were: entry and accessibility to the settings, previous employment in two of the three settings resulted in the researcher being known to unit and administrative personnel; patient census and population, all of the pediatric units studied maintained a fairly consistent census but served varied patient and family populations; geographical location and consideration of the researcher's time and energy. What follows is a description of the structural conditions of the three settings. These conditions will be explored in more detail in the analysis of findings to show how they influence what occurs in the setting and how parents react and interact under these varying conditions.

Study Setting Description

The University Hospital

The university hospital has as its goals teaching, research and public service stated in that order. The emphasis on teaching is reflected in the many educational programs for medicine, nursing, pharmacy and allied health professions. They are also the recipients for a large amount of research funding which in turn influences the patient population in terms of their illness conditions.

The written department of nursing philosophy reflects that of

the hospital and has as its primary prupose the provision of quality nursing service to patients and families. The stated pediatric unit philosophy and goals give emphasis to care of the child and includes the family component. The pro-parent orientation of the unit is operationalized in an active "Care Through Parent Program" whereby parents are encouraged to become involved and participate in their child's care to the extent with which they feel comfortable.

The pediatric unit patient population consists mainly of children with chronic and life-threatening diseases. The average census of the unit was 20 to 25 children, with 50% of the patients at any time being re-admissions for follow-up care. The families are of all socio-economic levels and live mainly outside of the city in all areas of the northern part of the state. A small percentage of the families live within the city and a few come from out of state.

The physical structure of the unit includes both private and ward rooms for patients. The unit is a long I-shaped hall with a nursing station located at the center of the unit. A playroom which is equipped and supervised by recreational therapists, a school-room used by part-time teachers, an outside courtyard, parent waiting areas, a treatment room, storate areas and a kitchen comprise the other physical aspects of the unit. Office and conference areas include nursing and house officers conference rooms next to the nursing station and an office for the head nurse and the nursing clinical specialist. The activity level of the unit is high with many persons in the area at any given time.

The nursing staff consists of 90% registered nurses and 10% auxiliary personnel. The majority of the registered nurses hold university degrees. These include one with a Doctor of Nursing Science, one with a Masters of Science, twenty of the staff nurses have a Bachelor of Science in Nursing, and two have a Nursing Diploma.

Three full time unit secretaries cover all days and all shifts except for the 11-7 shift on weekends. Nursing students from the university use the facility for clinical experience.

The medical staff consists of fellows, residents, interns and medical students who are divided into four medical teams. Each team has an attending physician in charge. All of the patients are seen by the house officers who write orders and plan medical treatment in consultation with the attending physician in charge of the team. The house officers rotate every four to six weeks throughout the various pediatric in and out patient departments. The position of team attending physician is also a rotational one changing every month. Approximately 10 to 15% of the patients are admitted through private pediatricians. These patients are also seen by the house officers who manage the care in consultation with the private physician.

There are four full-time social workers, one for each of the medical teams. Two full-time recreational therapists are in charge of the play program and recreational activities. Volunteer

grandparents are on the unit approximately four hours during the day to bathe, feed, hold and play with the children.

Parent facilities consist of a parent waiting area located outside the main unit with no view of the unit. This room contains a television, coffee machine, public telephone and twelve chairs. A bulletin board in the area has information regarding commonly used medical terms and their meanings, lab tests commonly done and the normal values, and the location of restaurants and guest houses in the area. Another waiting area with four chairs is located at one end of the unit proper. A large coffee pot at the nursing station is kept going twenty-four hours a day for both parents and staff.

A daily parent meeting is held, the main purpose of which is to assign beds for parents staying over night and to orient new parents to the physical aspects of the unit. Ten cots are available to parents who wish to sleep there at night and are assigned on a priority basis according to specific qualifications such as age and stage of illness of the child. These cots are set up in the playroom at night. Approximately eight parents stay over every night. All of the private rooms have fold out beds, and parents may stay over night in those rooms also. There are shower facilities available to the parents, and also a washer and drier on the unit.

A weekly parent-nurse meeting is held. This meeting is attended by one or two staff nurses and as many parents as are interested. The purpose is for parents and nurses to get to know

one another better, and to discuss problems or concerns of parents.

On admission each parent is given three sheets of paper explaining the physical layout of the unit, the type of patients admitted on the unit, the team system of the staff, the names of key individuals who will be caring for the child, the "Care Through Parent Program," and the weekly parent-nurse meeting. There are no set visiting hours and parens have access to the unit at any time.

The County Hospital

The county hospital has as its goals public service, teaching and research. This hospital is an integral part of the City and County Health Department and is concerned with the health needs of the city and county. The in and out-patient facilities provided attempt to meet these needs and serve persons for whom no other resource is available.

The written philosophy of the nursing department images the goals of the hospital and speaks to the delivery of quality nursng care to individual patients. The family component is included in terms of evaluating and meeting teaching needs. The written pediatric unit philosophy speaks to the provision of quality care for the child and support for the parents.

The pediatric unit population consists mainly of trauma cases such as accident victims and battered children. Patients with acute short term illnesses and some children wtih chronic, life-threatening diseases are also admitted. The average census of the unit is 15

patients with approximately 25% of these being re-admissions for follow-up care. The majority of families are in the lower socio-economic level and live within the city. Seventy-five percent of the families are from minority ethnic groups and approximately 30% of these are non-English speaking. The pediatric patients are admitted either through the emergency room or through the out-patient clinics, and do not come via a private physician.

During the course of this study the pediatric unit moved from its original setting into a newly build faciltiy. The move and its affect on the study was discussed in the data collection section of the previous chapter. The move did not affect the type of patients admitted or the staffing patterns. Although the bed capacity of the new facility is larger the census remained the same during the time of the study. The physical layout of the new facility will be described. The unit is H-shaped with patient rooms along the outside walls. The rooms are semi-private or wards. The nursing station is located at the entrance to the unit. A playroom is located at the far end of the unit and is equipped with toys. There are no recreational personnel to direct play activities. A room adjacent to this playroom has been designated as a recreational area for teenagers. This room is also used for conferences and for parents who sleep over night. Nursing and house officer conference rooms and an office for the head nurse are adjacent to the nursing station. A treatment room, storage areas and a small locked kitchen area comprise the remaining

physical structures of the unit. The activity level of the unit is low to moderate.

The nursing staff is comprised of 60% registered nurses and 40% auxiliary personnel. The educational background of the registered nurses includes three who have a Bachelor of Science in Nursing and the remaining ten staff have either a Nursing Diploma or an Associate of Arts Degree. One unit secretary works days through the week. Both registered nurse and licensed vocational nurse students use the facility for nursing experience.

The medical staff consists of residents, interns and medical students who rotate through the in and out-patient pediatric services every four to six weeks. All patients are seen by the house officers who write the patient orders and who are primarily responsible for planning the medical care in consultation with an attending physician. The position of attending physician is on a one month rotational system.

One full-time social worker is assigned to the unit. Volunteer grandparents come daily to help bathe, feed, play with the children, run errands and transport the children to other hospital departments.

Parent facilities consist of a parent waiting room that is located outside of the unit and down a hall. This room contains eight chairs. Parents also occasionally use the room designated as the teenage room to smoke. Two roll-away beds are available for parents staying over night. These are allocated on a priority

basis depending on the gravity of the illness of the child. A physician's order must be obtained before a parent can stay over night. Approximately three parents stay over during any week. Visiting hours are from 8:00 a.m. to 8:00 p.m. Written information is not routinely given to parents on admission.

The Private Hospital

The private hospital states in its philosophy the goals of public service, teaching and research. This is in keeping with the philosophy of a private institution which attempts to be responsive to the community it serves and where the patients are admitted by private physicians who have privileges to practice at that hospital.

The written nursing department philosophy supports that of the hospital in providing a nursing care support system to further the goals of service, education and research with emphasis on the individual patient. The pediatric unit philosophy is written in a manner that focuses on both the child and the family in terms of nursing care, educational needs and well-being. Parent participation in care is stated as being encouraged and is reflected in the functioning of the unit.

The pediatric unit patient population consists of scheduled and non-scheduled admissions of children with medical and surgical illnesses of both an acute and chronic nature. The average census is 15 to 20 patients with 20% of these being re-admissions for follow-up care. The families are mainly in the middle socio-economic

level and live within the city or outlying areas. Eighty percent of the patients have private physicians and 20% are admitted under the pre-paid health plan provided through the out-patient clinic. Care for the clinic patient is also supervised by an attending physician. Medical staff in this position rotate every month.

The pediatric unit is H-shaped with patient rooms along the outside walls. There are private, semi-private and ward rooms. The nursing station is located at the entrance of the unit. A playroom is at the far end of the unit and is staffed by one recreational therapist. Nursing and house officer conference rooms adjoin the nursing station. The head nurse office is at the back of the unit. There is also a treatment room, storage areas, and kitchen facilities on the unit. The activity level of the unit is moderate to high with shift change and early morning being times of greatest congestion.

The nursing staff consists of 66% registered nurses and 33% auxiliary personnel. Of the registered nurses three have a Masters of Science Degree, seven have a Bachelors of Science in Nursing, six have a Nursing Diploma and two have an Associate of Arts Degree. Two full time unit secretaries cover the day and evening shift during the week and one part-time secretary works on days during the week end. Both registered nurse and licensed vocational nursing student use the facility for nursing experience.

The medical house staff consists of residents, interns and medical students who rotate every four to six weeks throughout the

in and out-patient pediatric services. Patient orders and medical treatment plans are written by the house officers for all the patients in consultation with the private or attending physician. Each child is visited daily by his private physician.

One full-time social worker is employed on the unit. One full-time recreational therapist is responsible for play activities and is assisted by volunteers. Other volunteers come to the unit daily and help bathe, feed, play with the children and run errands for the staff.

Parent facilities consist of a parents waiting area adjacent to the unit with a glass wall looking onto the unit. This room can accommodate 10 to 15 persons. Parents whose child is in a private room may stay over night in the room. For parents with children in semi-private or ward rooms there are eight cots available for them to sleep over night. These cots are set up in the playroom and are allocated on a priority basis of age and illness of the child, or a first come first serve basis. Approximately three parents sleep over every night. There are shower facilities for these parents. There are no set visiting hours and parents have access to the unit at any time within the twenty-four hours. No written information about the unit is given to parents on admission.

The recreational therapist is responsible for conducting a hospital orientation program during the week for surgical patients and their parents. The purpose of this program is to give information regarding routine surgical preparation and procedures and to discuss concerns of the children and/or parents.

Summary and Analytical Implications

The purpose of this somewhat lengthy description of the settings is to give the reader some feel for the study settings and to point out similarities and differences in the existing environmental and structural conditions that have a bearing on the analytic framework of this research. (A summary outline of this information is located at the end of this section. See page 70.)

All of the hospitals have as their goals service, teaching and research, however the emphasis on these goals differ as is seen in the priority on teaching and research in a university hospital in contrast to the priority on service and teaching in a private and county hospital. These goals affect the type of patient that is admitted, the community that is served, the patient and family population of the unit, and the pediatric staff.

The stated institution and unit orientation to the patient and the family can be viewed on a continuum from a patient focus to one of patient and family. This is reflected in the policies governing visiting of parents, the space made available to parents, the time alloted to parents in terms of meetings and in the day to day interaction of staff with parents.

The physical structure and the activity level on the unit can also affect staff-parent interaction. Although the physical aspects of all the units are similar, parent use of and acc-sss to the unit differs in light of the philosophy and orientation of the hospital and the pediatric staff. Activity levels among the units differ

and also differ within a given setting at various times of the day. As the activity level of the unit increases, the rate of mobility of the staff is increased. This in turn can affect the accessbility of staff to parents and parents to staff.

At the time of this study each unit had their full complement of nursing staff. However the ratio of registered nurses to auxiliary staff differed in the settings. This variation had an affect on the level of personnel with whom the parents had most frequent contact and the type and amount of information accessible to an individual staff member and therefore to the parents.

All of the hospitals have a teaching program for residents and interns so that parents in all study settings dealt to some extent with house officers. All parents were subject to the rotational system of the house officers and the attending physicians resulting in interruptions in the continuity of physician-parent relationships. Families who had a private pediatrician had the advantage of being able to maintain an on-going relationship with a consistent medical person. The number of persons providing a support system to parents, such as social workers and interdisciplinary personnel varied and affected the work structure of the staff, the division of labor on the units and the resources available to parents.

The parent facilities and programs provided, and the amount of parent participation in care, varies among and within the settings. Again, this is reflective of the philosophy, goals and orientation of the institution and of the individuals working on the units,

and is also influenced by the amount of staff available, patient census and acuity level of patient illnesses, and the work structure.

Despite varying situational facilities or constraints parent's concerns were found to be similar in all the settings, that is, their initial uncertainty with regard to the expected role of parents in a hospital setting, their need for information regarding the child and their desire for some control over what was happening to the child and to them. Patterns of parental role management vary within the situational circumstances and conditions and were affected by them. In turn, the way the parents manage their role affected the functioning of the unit and the work of the staff.

In the analysis of findings parental response and behavior will be examined in light of the total situation. This study does not attempt to prove that a specific condition is the cause of a specific reaction or response, but attempts to explain variations among and within conditions and to delineate patterns of response to what were found to be significant categories of the situation. These key categories will be elaborated in the analysis of findings in Chapter IV.

Figure 1

Study Setting Descriptions

	University Hospital	County Hospital	Private Hospital
Institution and Nursing Department goals	Teaching, research, service.	Public service, teaching, research.	Public service, teaching, research.
Pediatric unit philosophy	Patient-family orientation.	Patient orientation.	Patient-family orientation.
Patient population	Chrnoic and life-threatening disease. Census 20-25.	Trauma, with some acute and life-threatening diseases. Census 15.	Medical and surgical conditions, both acute and chronic. Census 15-20.
Family	80% Caucasian. All levels of socio-economic class. Live mainly outside the city.	75% Minorities. Majority lower socio-economic class. Live within the city.	80% Caucasian. Majority middle socio-economic class. Live in the city or near outlying areas.
Staff	90%-Registered nurses 10%-Auxiliary staff. Rotating house officers and attending physician. 10% patients have private pediatrician. 4 Social Workers. 2 Recreational therapists.	60%-Registered nurses. 40%-Auxiliary staff. Rotating house officers and attending physicians. No private pediatricians. 1 Social Worker. No recreational therapist.	66%-Registered nurses. 33%-Auxiliary staff. Rotating house officers 80% patients have private pediatrician. 20% have attending physician through clinic. 1 Recreational therapist.
Parent facilities	Main waiting area adajacent to unit. No set visiting hours. 10 cots available and 7 private rooms with beds for parents. Written information to parents on admission. Daily parent meeting for bed assignment to parents rooming-in. Weekly parent-nurse meeting.	Waiting area outside unit. Visiting hours 8 a.m. to 8 p.m. 2 cots available for parents rooming-in. Doctors write order required for parents rooming-in. No formal parent meetings No written information to parents.	Waiting area adjacent and visible to unit. No set visiting hours. 8 cots available for rooming-in. No written information to parents. No formal parent meetings. Hospital adjustment program during week for surgical patients and parents.

Section II

The Hospital Situation

This research attempts to explain parental behavior in the pediatric in-patient setting. The study settings in which parents were observed and interviewed have been described. The focus of this section is the hospital situation within which the parental role is managed.

Role management is not unique to parents in the hospital, indeed not unique to parents. All individuals play a variety of roles in their lives; friend, parent, lover, husband, wife, sibling, employer, worker, student, teacher to name a few. The structural conditions within which these roles are enacted and the manner in which the roles are managed differ, as well as the goals to be achieved. The situation within which an individual finds himself determines to a great extent the enactment and management of his role.

In order to highlight the hospital situation, and to lend validity to the situational aspect of role management, some characteristics of the home setting are compared and contrasted with those of the hospital setting. The contrasted characteristics of the two situations are: environmental control which includes input and access regulation, and patterns of activity; goals, including the aspects of rule-making and enforcement; the power base or locus of control; and position and role clarity.

Comparison of the Home Setting and the Hospital Setting

Environmental Control

Control over one's environment varies with different situations. Within the home, parents manage their environment. They choose the physical structure in which to live and the furnishings of that environment. It is a familiar place that belongs to them, it is theirs. The hospital environment on the other hand, is strange and unfamiliar to parents, especially to those whose child is being admitted for the first time. Parens describe the hospital as a "big place," "like a giant machine," "frightening and intimidating," and "like being in another world." One mother put it this way, "it was all strange and new. Its like going to a different country, you don't know where you are or what you are doing" (Parent Interview #3). Parents can and do react to this physical environment, however overall control and management of the hospital environment is not within the scope of parental action.

The environment of the home for the most part is health and growth oriented. The focus in the hospital is on pathology and disease. In the hospital the parents and child are surrounded by illness. The father of a chronically ill child related, "at home you can try to forget it and live, here there is no getting away from it, its all around you" (Parent Interview #11). In the hospital parents are forced into an awareness of sickness and pain.

The family in the home setting can control input and regulate access of other persons to the home and the family. Once in the hospital parents are bombarded with input and surrounded by "strangers day and night," a multitude of "different persons and different personalities." Parents often have little control over the persons with whom they and their child come into contact. House officers and nurses are assigned to care for their child. "You find a nurse that you wish were on duty every day, but she isn't and there is nothing you can do about it" (Parent Interview #6).

At times there is also a decrease in parental access to friends and family especially if the child is hospitalized a long distance from home. Parents speak of being "lonely" and missing the support and companionship of friends and other family members. Parents are surrounded by persons over whose presence they have no control, while at the same time being limited in their access to family and friends outside the hospital.

Families function within their established patterns in the home with some consistency. This is not to say that changes in conditions or occasional emergencies do not arise. But overall activities and daily routines are carried out with a fair amount of predictability and in patterns consistent with personal needs. Hospitals, although they have established patterns and routines, are prone to frequent changes and variations that affect these patterns. The patient population in terms of numbers and acuity

of illness can vary from shift to shift, or day to day, affecting the flow and pacing of work. The patient's illness can follow an expected course from sickness to health, can vary anywhere along that continuum, or can change unexpectedly for the worse. Hospital staff vary in their levels of knowledge, experience and skill, in day to day consistency due to rotations and days off. Parents cannot control these changes, but are caught up and affected by them.

Hospitals are not entirely insensitive to the reactions and needs of parents and children and do make some attempts to "normalize" the environment. Exactly what is done in this regard varies with different hospitals. Some examples of normalizing attempts are the cheerful decor of the pediatric unit with bright colored walls and decorations, television sets, provisions for parents and children to eat together, recreational activities for the child, parent facilities such as waiting areas, and the use of showers, washers and driers. There is however, a realistic limit to what can be done in terms of simulating a home-like familiar and comfortable environment within the hospital. Despite attempts to normalize the environment the fact remains that the hospital is a place of work, a place where sick children come to be cared for, and that parents have limited control over the existing environment.

The individual patients and families are temporary and transient in the hospital setting whereas the staff of health professionals is relatively stable. Although the individual

patients vary, the work of providing health care and treatment for the patient is the raison d'etre of the hospital system. The hospital environment is therefore managed and controlled by the staff in order to facilitate this work.

Goals

In general it can be said that the family strives to achieve many goals concurrently, that is, physical, emotional, psychological, economical, social and educational. The focus of attention is the family as a whole or individual members at different times. When a sick child is brought to the hospital, that child and the goal of health, becomes the focus, not only for the family but for health professionals as well. The health and well-being of the child becomes a priority. Both fathers and mothers may take time off or a leave of absence from work to be with the child. Family life revolves around arranging time to be with the hospitalized child as well as managing the activities of everyday living. As one father said, "Life has to go on. You are here but your head is in many places worrying about your child that is sick as well as the family at home, and your job. Amd most of all you want to be here with your child" (Parent Interview #2). The health professionals in the hospital have the added dimension of providing care for many sick children at the same time. Their focus is not only the sick child, but is broadened to include all the sick children who rely on their care.

In the home setting methods of goal achievement are a decision of the parents or a shared decision of family members. In the hospital the means by which the goal of child health and well-being is achieved lies to a great extent in the hands of the health professionals with minimal sharing in the decision on the part of the family. This can at times result in stress and conflict between parents and staff. The methods of goals achievement in the hospital setting are primarily decided by the health professionals who must incorporate decisions regarding not only individual patients but all the patients under their care. The parents as non-professionals have not only limited knowledge with which to determine methods of goals achievement regarding medical care but also a focus that is directed toward their child only.

In the home parents can establish rules and patterns of enforcement, and do so based on their perception of family member needs. In the hospital rules and policies are set up by the institution and enforced by the staff. They are based on the need to accomplish the work to be done in what is perceived or rationalized to be the most effective and efficient manner. Rule enforcement in the hospital can vary and criteria used for "bending the rules" may be weighted more heavily in the service of work and the overall ward order than for the individual needs of parents and child. As one staff member said, "We may bend the rules in certain cases, but not if it is going to seriously interfere with getting the work done" (Staff Interview #17).

Power Base

The base of power in the home setting lies within the family and most often with the parents. They are in a position to say what goes on. The power base in a hospital is in the hands of the staff, the health professionals, with varying levels of power based on position within the hierarchical structure.

Parents bringing their child to the hospital come seeking help. This of necessity puts them in a dependency position. In the home they have the knowledge and skill to deal with day to day events and occasional minor illnesses. However once a child becomes sick enough to be hospitalized the parents must depend on the knowledge and skill of the health professionals. They relinquish a certain amount of control over that which they value, that is, their child. The locus of control in the home is with the parents whereas in the hospital it is located primarily with the staff.

Position and Role Clarity

Within the family system each person has a position, a role and an identity within that system. Major roles are acquired or assumed and a fair amount of role clarity exists, with a place for everyone within the family system. Within the hospital system the health professional has a position by virtue of his/her employment and/or authority and consequently a role to play. The child, in the position and role of patient, legitimately belongs

within the system, there is a specific place for him. The parent on the other hand, does not have an established, clearly defined position in the hospital system. Therefore, although the parent retains his/her identity as a parent, the lack of an established position within the hospital system results in uncertainty for the parents regarding their role enactment. They have a parental identity but no clearly specified role to play. Parents frequently related, "I don't know what they expect of me here," "I'm not sure of what I can do." How a parent behaves in the hospital, and how they determine their role in that situation is the essence of the analysis of this study.

Summary

The purpose of this section is to provide a situational set to the analysis of findings that follow. The hospital setting differs from the home setting for parents in a number of important aspects. Control of the hospital environment is the perogative of the institution and the staff. The hospital is a strange and unfamiliar place for parents and can be intimidating. Although there is an overall pattern of activities in the hospital it is a setting in which there are frequent changes in conditions that in turn affect the child and the parent. The hospital is a place of work. Rules and policies are determined by the institution, enforced by the staff and are based on the need to provide care for the patient that is medically effective and organizationally efficient. Control over what happens

in the hospital setting, when and how it happens, is largely within the realm of the health professionals, who are in positions of authority because of their knowledge, skill and employment. Within the hospital system there is a legitimate position and role for staff and for patients. The position of parent is ambiguous and lacks clarity of definition, resulting in parental uncertainty with regard to role performance. The enactment of familial roles is further altered by the setting and attendant circumstances.

When a child is hospitalized the family system of non-professionals comes into contact and interacts with the hospital system and the staff of health professionals. The focus of attention is the sick child and the goal is the health and well-being of the child to whatever extent that is medically possible. The parent in the hospital setting seeks to manage his/her role as a parent, and does so to a varying degree of satisfaction because of, or despite, certain variables in the situation. The following chapter outlines the key categories that were discovered to be influential in terms of parental behavior in the pediatric in-patient setting.

CHAPTER IV

SITUATIONAL ROLE MANAGEMENT: KEY CATEGORIES

The purpose of this study is to explain parental behavior in the in-patient pediatric setting. This is done using the discovered analytic framework of Situational Role Management. Situational role management is defined in this study as the process of directing one's behavior with regard to conditions and attendant circumstances in order to achieve a goal. Put another way, it is how a person behaves in a given situation in order to get what he wants. In this study the person referred to is the patient, the behavior encompasses the role of the parent, management includes the processes by which the parent directs his behavior, the situation is the hospital setting and the goal is the health and well-being of the hospitalized child.

In every situation within which roles are enacted, conditions and factors exist which influence role behavior. The prupose of this chapter is to explore the conditions and factors comprising the key categories identified in this investigation. These categories are the result of the researcher's abstraction, conceptualization, and ordering of the events and conditions that were observed and recorded in the process of data collection and analysis. The categories presented were determined to be significant in relation to parental behavior and to the situational role management of parents in the in-patient pediatric setting.

This chapter is divided into four sections with each of the sections devoted to one of the key categories. The four categories that will be explored are: orientation, the structure of work, balance of power and information exchange. Orientation is defined as the philosophical perspective of one person or group toward another person or group which sets the stage for their interaction. The structure of work takes into account the kinds of activities that occur in the setting and the persons who share in the division of labor. Balance of power refers to the control aspects of a situation, that is, what persons have the say about or direct what occurs in the situation. Information exchange refers to the transmission and receiving of messages in the setting. Information exchange is viewed both as a source of communication and as a means of social control.

Cross-cutting these key categories are the categories of temporal aspects and territorial boundaries. Cross-cutting categories are those which link up with other categories and serve to make them more analytically dense. That is, cross-cutting categories are analytically related to one or more of the key categories. Temporal aspects takes into account time related factors such as: parents who are inexperienced versus those who are experienced in terms of the hospital setting and the child's illness; the length of illness or illness trajectory of the child; the amount of staff time in relation to the work to be done; and the amount of time a parent spends in the hospital setting.

Territorial boundaries refers to the physical environment and use of space, and also to the more abstract realm of boundary maintenance between health professionals and the parents as non-professionals.

Section I

Orientation

Orientation is being defined as the philosophical perspective of one person or group toward another person or group which sets the stage for their interaction. As a key category of situational role management orientation, encompasses the philosophical perspective of the institution, the pediatric unit and the staff towards parents, and that of parents toward the hospital and the staff.

Institutional Orientation

The philosophical perspective of the hospital is contained in the written expression of its philosophy and goals. The hospital philosophy and goals are global in scope and refer to the majority of activities that occur within that institution. They are not merely words but dictate the types of services provided by the hospital, which in turn have a direct bearing on the patient and family population who utilize these services. On the other hand the needs of the patient and family population of a given hospital also influence the types of services required and may serve to influence the hospital orientation towards the patients and families. So that there is an interrelationship between the hospital orientation, the types of services provided and the patient and family population who utilize the services.

The institutional orientation determines the establishment of policies and rules governing the activities that occur within the

setting. For example, policies regarding visiting hours control accessibility of the family to the child and vice versa, and reflect an institutional orientation that is either patient-focused or one that is inclusive of both the patient and the family.

Institutional philosophy and goals are influential in decisions regarding budgetary allotment for staffing. For example, an institution that gives a high priority to teaching will expend a certain amount of its budget to recruit and employ house officers and to open its facilities for use by students in the health professions, which in turn influences the level and types of staff dealing with patients and families. Budgetary expenditures for a pediatric unit will determine the amount of nursing staff employed on the unit. This in turn affects the structure of the work and division of labor, both of which have an effect on the number of staff available to patients and family and the time alloted for individual patient and/or family care.

The philosophy and goals of the hospital also have an effect on the type of existing physical structure of monetary outlay for expansion or remodeling, and therefore affects the type of physical environment in which the patient and family are located. Several staff in this study related how it was difficult to help parents feel accepted and welcome on the pediatric unit because of the existing small patient rooms that did not facilitate parental presence at the bedside, and the lack of facilities for parents, such as beds for parents who want to room-in, or a place for

parents to call their own such as a lounge area.

The philosophy and goals of a given insitution which comprise its orientation towards patients and family influences the types of services provided by that institution, the rules and policies governing the activities in the setting, budgetary allotments for specific services, and the physical environment of the institution. All of these factors have an indirect influence on individual patients and family members and their position and role in the setting.

Pediatric Unit Parent Orientation

Individual units within the hospital are affected by the overall institutional philosophy and goals and in turn serve as the arena within which rules and policies are implemented. Each pediatric unit had its own written philosophy and goals which were available to the staff only and were indicative of the overall unit orientation towards parents, and which varied from minimal reference to the family to consideration of the family in relation to all aspects of patient care. The unit orientation provides the set with regard to the amount of parental presence allowed and parental accessibility to the child, the availability of written information for parents and the tone of the admission procedure.

Visiting hours for the pediatric units are usually extended in comparison to the rest of the units of a general hospital. Parental accessibility to the child is institutionally controlled by visiting hours. The staff may simply state the visiting policy,

leaving the parents to decide when and how often they will visit within the stated time frame. Or the staff may interpret this policy for parents in a way that is highly suggestive of the staff's expectations of parental behavior. For example, one staff member said, "visiting hours are from eight to eight but we try and encourage parents to come after twelve in the morning so that our morning work is done" (Staff Interview #12).

The unit can, as a matter of routine policy, make written information available to parents on admission. This information outlines the unit functions and orientation. Providing written information to the parents about the unit is one way in which the unit orientation can be shared with the parents. Written information to parents can also be viewed as a symbolic gesture of parental inclusion, one that allows them an initial grasp of the workings of the unit and their place in the setting.

The routine admission procedure for a pediatric unit is indicative of the unit orientation. The admission procedure can be either patient focused or patient and family focused. A patient focused admission is one in which the attention of the staff is centered on the child, relegating the parents to the background. Parent and child are often separated during the admission. Parents are asked for information but minimal information is given to them by the staff. No mention is made of the parent's place in the setting or the role they are expected to play.

An admission procedure that focuses on the patient and family is one in which the staff gives attention and relates not only to the child but to the parents as well. The parents are not separated from their child and information is sought from as well as given to the parents. Some mention is made of the parent's role in the setting.

Because the admission procedure provides an initial set with regard to the unit orientation the situation in which the staff is child focused leaves the parent feeling "left out" and "unimportant." Whereas the patient and family focused admission indicates to parents that they are part of and included in the process of their child's hospitalization.

Another dimension of unit orientation is language. The language or words used to refer to the parent of the hospitalized child reflects the unit orientation. Church (1961) states that, "...language arouses us to feeling and action...Words orient us, not to themselves, but to a realm of action, whether actual, potential or purely symbolic" (p. 129). If a parent is constantly referred to as a visitor this implies an outsider position with its consequent behavioral expectations of being nice, polite and non-interfering. Whereas the use of the word parent implies a necessary and vital relationship and bond of the parent with the child. One mother who was told that visiting hours were over and that she would have to leave, was shocked. "It'll be a cold day in hell before I think of myself as a visitor, that's for aunts and grandparents."

In this instance the unit orientation towards parents and this mother's self orientation were inconsistent and this issue was accentuated by the language used.

Territorial boundaries and the use of space also symbolize the unit orientation. Parental access to areas within the unit such as treatment room, kitchen and storage areas indicates a sharing of space between parents and staff and loose territorial boundaries. On the other hand a parent may be relegated to the child's room at his bedside with other areas on the unit being the territory of the "staff only." For example, the kitchen area, storage or linen supply areas may be considered "off limits" to the parents. In this case parents must depend on the staff's time and availability to retrieve the necessary or requested items. Symbolically this sets up territorial boundaries of space between the health professional and the non-professional or parent. Regulation of parental access to what is considered staff territory is not always constant and can diminish as the length of time the parent is present increases. That is, maintenance of strict territorial boundaries may be altered over time.

Staff Orientation Towards Parents

Individual pediatric staff members have a parent orientation of their own. This orientation towards parents may or may not be consistent with that of the overall unit orientation and is affected by the strength of this unit orientation and the reward system, if

any, to the staff for working with parents. As an illustration, evaluation of the staff that takes into account, documents, and gives credit to s-aff for working with parents and upholds a unit orientation that is inclusive of parents provides incentive to the staff. Other rewards for staff come from acknowledgment of colleagues, physicians and hospital management, such as the head nurse or supervisor, that they have "done a good job with families." There is also the personal reward a staff member feels, "knowing that you did a good job with the patient and the family," as one nurse put it. If the pediatric unit does not foster an inclusion orientation toward parents, comments acknowledging working with parents are not forthcoming from peers or hospital management, the reward system is minimal or lacking and the incentive to the individual staff members decreases. In this situation rewards come from personal satisfaction alone and are not supported by the system.

Staff orientation towards parents can be described as being an inclusion orientation, middle of the road, or an exclusion orientation. In each of the study settings individual staff members were found whose parent orientation corresponded with one of these perspectives. The majority of staff however, fell into either an inclusion orientation or a middle of the road orientation.

The orientation of the staff was indicated by their comments relating their professional beliefs and philosophy, and also in their observed interactions with parents. Staff who have an

inclusion orientation towards parents consider parents as part of their work and necessary for the care of the child. Working with parents as well as with the child is rewarding to them. As one staff nurse related, "Parents are accepted as part of my work and the environment. They are part of the total care of the child, part of taking care of children" (Staff Interview #3).

The orientation of the staff towards parents is also reflected in their expectations of parents. The staff with an inclusion orientation accept parents and see them as necessary and important persons in the healing process of the child. Parents are therefore expected to participate in the child's care and verbal contracts between parents and staff establish the role each will play in relation to the sick child. Parents in this case are expected to ask questions regarding the treatment and care of the child and to provide information about the child relevant to care. They are expected to be informed about the treatment of their child. Interaction under these conditions is most often initiated by the staff who seek to keep parents informed and involved.

The territorial boundaries between the professional and the non-professional are loose. The staff are willing to share with the parents the care of the child, control over what happends to the child, and information. This is not to say that staff who possess an inclusion orientation towards parents are never upset by parents or never consider them to be a problem, but on the whole their attitude is one of acceptance and inclusion of parents in

the healing process.

Staff with a middle of the road orientation vacilate between inclusion and exclusion depending on the "type" of parent present and their own need to accomplish the work to be done, that is, taking care of the child. Middle of the road staff are tolerant and/or accepting of parents but qualify their statements regarding parents based on the amount of parental interference with the work to be done in caring for the child. "Most of the time I don't have any problem with the parents, in fact I kind of like having them here. But sometimes we have a lot of parents around, and they won't let you do things for the kids, that's when I have problems with them" (Staff Interview #10). They allow a limited place for parents in the division of labor and can tolerate parents in limited numbers and for limited amounts of time.

Parental presence and functioning is allowed, but controlled to a large extent by staff with a middle of the road orientation. They expect parents to be present and to be of emotional support to the child, and at times to assist with some of the child's care. However, the staff for the most part controls what the parents can do with respect to caring for the child and when they will be included or excluded in the division of labor thus maintaining the territorial boundaries between the health professional and the non-professional. The parent is expected to go along with the treatment plan for the child initiated by the physician and carried out by the nursing staff. Interaction in this instance can be

initiated either by the parents or the staff.

No staff member interviewed openly stated they were against parents being present in the setting. However an exclusion orientation was indicated in subtle comments about parents, and in staff interactions with parents. Constant use of the term "visitors" when referring to parents or comments such as, "as long as they are out of the way while we do our work" reflect an orientation of persons that have difficulty accepting parents on the pediatric unit. This group views the parent as a threat to their own competency, role, and control. "Granted the parent knows the child better than you do, but when they are always questioning what you are doing and why, its like they are questioning your ability to take care of their child. You don't like that in your own little setting here" (Staff Interview #15).

An exclusion orientation towards parents is reflected in the exercise of power by the staff in their attemtps to limit parental access to the child, and exclude parents from a place in the division of labor. Staff with an exclusion orientation towards parents are quick to suggest that parents leave the setting, using the rationalization that it would be better for the child. These staff members rarely initiate interaction with parents and respond to them only when the parents seek them out. Strict territorial boundaries are maintained between the health professional and the non-professional. Parental presence is tolerated by the staff

and although the parents are expected to visit the child and be of support to the child, they are also expected to remain on the periphery and not to make demands or interfere with the staff who are caring for the child. These staff members prefer to do all the care for the child, including activities such as bathing and feeding, which are usually considered within the scope of knowledge and ability of the parent, except in unusual cases.

The factor of time is related to the staff orientation towards parents. With the recent changes in hospital policies toward parental presence in pediatrics, more and more parents room-in with the child. This means that parents are present during most of the twenty-four hours of the day. Pediatric staff who have worked the night shift for a long time tend to fall mainly into the middle of the road orientation or an exclusion orientation. They are not accustomed to having parents present to question or interfere with their work, and their need for adjustment to increased parental presence is greater than on the other two shifts where parents are normally present.

The time factor is an important consideration on the evening shift where staff may realize the need to work with parents and philosophically be of an inclusion orientation towards parents but are restricted in practice due to limited staff and the amount of work to be done. The numbers of parents present on evenings is usually greater than on the day shift, however the numbers of staff working is decreased from the amount of days and therefore the

the patient to staff ratio is increased limiting the amount of time available to staff for dealing with parents. "You see the parent needs someone to talk to or has concerns, but most of the time you just don't have the time to spend with them" (Staff Interview #5).

An individual staff member's orientation toward a specific parent may be altered over time, that is, time the parent is present in the setting and amount of time the staff is able to spend with the parent. The more time the staff is able to spend with the parents, the better they get to know them and the more comfortable they are with them. This in turn can serve to alter their orientation towards an individual parent from one of middle of the road to one of inclusion.

Parent Orientation Toward the Hospital and the Staff

The majority of parents perceived the hospital as a place where their child can be helped, and hopefully cured of their illness. Although it may be "frightening" or "scarey" because of its size and unfamiliarity, the hospital represents a place of hope for them and for the child. "It's a relief to have him here where I know they can help him" (Parent Interview #18). Parents of chronically ill children, whose child has been admitted to the same hospital time after time become familiar with the hospital and its environment. The strangeness lessens as they become more in tune with the things that go on in a hospital and the

treatment routines and procedures. As one mother stated, "it's become like a second home now" (Parent Interview #3).

Parents have to deal not only with the effect of the hospital on themselves, but are concerned with the effect on the child. They are concerned about whether the staff "care" about the child, and whether staff will "take over" the child, leaving them, the parents on the outside. Parent orientation towards staff varies from total acceptance of their ministrations, "they know what is best," to one of keeping a watchful eye on what is happening to the child because "things happen that should'nt and someone has to be there to watch what goes on."

The parents are entrusting their child to the care of the hospital staff, but not without concern. "We were faced with the problem of leaving her and whether people would be nece to her" (Parent Interview #2). The concern about whether the staff will "care" about their child is paramount for the parent, and a major determinant of the parent's orientation towards the staff.

The parents in this study perceived the staff as being either technically competent in their care of the child but "cold" and "business-like," or in addition to being technically competent in giving care, were "warm" and "human." The former can be termed technical caring and the latter humanistic caring. The parent's orientation towards individual staff members was based on their assessment of technical caring versus humanistic caring. The nurses who were perceived by the parents as giving technical care were

described as, "business-like;" they "talk down to you" and "do their work, but give you the impression they don't really care" and act like "its just a job to them and they are here to put in their eight hours and go home." In contrast parents were positively oriented and "more comfortable with" staff who did their work in a way that showed humanistic caring. These staff persons according to parents, "try harder," "go out of their way to do things" for the child, are "down to earth and don't treat you like you are below them" and are "concerned about the child and about you."

Parents expect that the staff employed are capable and skilled, "they wouldn't be here if they didn't know what they were doing, after all there is such a thing as amateurs and professionals" (Parent Interview #15). They expect the staff caring for their child to be knowledgeable regarding the child's care and treatment. A parental orientation that trusts and believes in the knowledge and skill of the staff results in an overall acceptance of the qualifications of the staff. Experienced parents are often more selective in their trust and reserve it for those staff members whom they have come to have confidence in. The parent's perception of the staff's competence can and does change with the occurrence of situations that tend to alter the level of parental trust. For instance, medications that are given late, a lack of what the parent considers proper attention to the child, or lack of humanistic

caring tends to decrease the level of parental trust towards the staff.

Parents who have experienced several hospitalizations of their child become more knowledgeable about staff and more realistic in their perceptions of them. "Like the first time I was here B. was uncomfortable and I'd ask if she could have some medication. They said yes of course, but a half an hour later nothing had happened and I was just beside myself. If that happened this time [third admission] well, number one I understand their problems a little better I think and have also gotten over the sense of the god-like quality of the people on the staff and would understand maybe why it could happen so I'd just go back and ask again" (Parent Interview #22).

Parents perceive the staff as sources of information regarding the child and his care. Parens differ however in their ability to retrieve this information. Some parents hesitate to ask questions not wanting to appear "dumb," and assume the attitude that "they'll tell me if I need to know." They may not want to ask questions about what is happening fearing they will antagonize the staff. Other parents respond to and need the encouragement of the staff to ask questions. Parents who are experienced in the hospital setting become more aggressive in seeking out information and have a more clear cut idea of what and whom to ask.

The socio-economic status of a family appears to have a relationship to the ability of the family to comprehend and manage the hospital system. In this study it was found that parents in the lower socio-economic class are often economically and psychologically unprepared for the hospitalization of their child. These parents tend to be less sophisticated in their approach to health professionals and the medical treatment and less knowledgeable with regard to dealing with the hospital system. They are more easily intimidated and are more conscious of the boundaries between themselves as non-professionals and the health professionals. They therefore ask fewer questions, feeling that the staff "knows what is best." Because of their lack of knowledge and skill to deal with the current health needs of the child, they are relieved to have the staff take over and they hesitate to interfere with the work of the staff.

Parents who were in the middle socio-economic class appeared to be less intimidated by the professional - non-professional boundaries. They viewed the staff as possessing professional knowledge and skill, but also as human beings and not God-like. These parents were better able to assert themselves and to make their needs known to the staff. They were observed to seek out the staff, question them, and provide information they believed to be relevant to the care of their child.

The parents in this study can be viewed on a continuum from naive parent to knowledgeable parent with regard to their interactions with the staff and their behavior within the hospital setting. The naive parent is one who has had no previous experience with the hospitalization of their child, everything and everyone is new and strange to them. They are less experienced and less aggressive in dealing with the staff. Their orientation towards staff and their level of trust in the staff is more tenuous making them more hesitant and cautious in their approach to the staff.

Knowledgeable parents who have experience both with the child's illness and the hospital setting are more accustomed to dealing with the staff. Their experience provides them with knowledge regarding how the work on the unit is accomplished and how to go about getting the information they require. Because of their personal identity as a parent of a sick child, their experience, and their knowledge of the staff, they are more aggressive in approaching the staff and in making a place for themselves in caring for their sick child in the hospital.

Summary

The institutional and pediatric unit orientation towards parents can be considered to be of a more fixed nature in comparison to the orientation of the individual health professional. That is, the hospital and unit philosophy and goals are expressed in written documents and include policies and rules governing events in the

setting. The staff, however, are the interpreters and/or enforcers of the established rules and policies related to parents, and can at times choose to ignore or bed the rules, and at other times to enforce the rules in order to control parental behavior.

Individual staff members possess a personal orientation towards parents which may or may not coincide with the institution and unit orientation. Staff have either an inclusion orientation, a middle of the road orientation or an exclusion orientation towards parents. Furhter this personal orientation of staff can be altered with time and interaction with individual parents.

Parents also have an orientation toward the staff and the hospital and this can vary. Parents who are inexperienced in the hospital setting have a more tenuous and less solidified orientation towards the staff and the hospital than those parents whose child has been hospitalized on multiple occasions. This latter group of parents have more personal and first hand experience upon which to base their perceptions and to validate their personal orientation.

Section II

Structure of Work

The structure of work refers to the organization of activities that contribute to the accomplishment of the job to be done and includes how the work is organized, who does the work and the kinds of work to be done. The dimensions of this category of work structure to be discussed are: the division of labor which includes formal and informal lines of work organization, staffing consistency, and ward work vis-a-vis medical work; and the time factor.

The Division of Labor: Formal and Informal Organization

The hospital is a place of work and the recognized territory and arena of the health professional. The work of the health professional is the treatment and care of patients, in this case, the sick child. In order for the system to function efficiently the workers must know what their job entails, what their responsibilities and the responsibilities of others are. Work is parceled out in a manner that accounts for the division of labor. In the in-patient pediatric units studied labor is divided along formal lines and informal lines.

The formal division of labor is based on the position of the health professional in the system and on job descriptions. For instance, it is the work of the medical personnel to diagnose, plan the medical treatment for the child and evaluate the treatm-nt. The private and attending physician supervise the work of the house officers and the child's treatment is planned by the house officers

in conjunction with them. House officers are each responsible for a certain number of patients. Their work is further divided among the various levels of resident, intern and medical student.

The nursing staff is responsible for implementing the treatment plan of the physician, for planning and providing patient care, and for evaluating patient care. The nursing work is formally organized according to an overall conceptual framework for practice. In the study settings either Team Nursing or Primary Care Nursing accounted for the formal organization of nursing care delivery.

Team Nursing was the primary mode of nursing care organization. Team Nursing utilized the concept of the team where a registered nurse is in charge of several team members who are responsible for the care of a designated number of patients. Geographical location determines which patients are assigned to which team. The length of time that staff members are on one team varies from one week to one month. The team leader decides which staff member is to care for a specific patient. This decision is based on the acuity of the child's illness, the type of care required, the number and level of staff available, personal preference and capability of individual staff members, and the job descriptions of the staff that specify the range of responsibility for the various levels of nursing personnel.

In Primary Nursing a registered nurse is primarily responsible for planning and/or giving the care to a certain number of patients during the length of their hospitalization. The type or class of patient illness, such as neurological disorders or pulmonary

conditions, rather than geographical location on the unit, determines which patients come under the responsibility of which primary nurse. These nurses rotate in caring for different types or classes of patients approximately every three months.

The formal organization of nursing care delivery determines the level of nursing staff that will be caring for the child and therefore determines the staff persons with whom parents will have daily contact. It also influences the number and consistency of persons providing care for the child and family.

Depending on the resources available for the pediatric unit and the type of personnel employed in the hospital, the work of caring for the sick child and his family may be further divided. Social workers assist in working with families, especially those with economic, social or emotional concerns and problems. Recreational therapists are responsible for the play and recreational activities of the children. Volunteers assist the nursing personnel in bathing, feeding and playing with the children. Students in the health professions utilizing the facility for experience also fall into the formal division of labor.

The number, the professional and experiential level of the persons at work, and the manner in which the work is divided dictates the number and type of persons who care for the child and come into contact with the child and his family. Parents can feel inundated by the variety and numbers of personnel. As one mother said, "at first there are so many people involved, the doctors, social workers and nurses, you don't know one form the other. As

time goes on you begin to get them sorted out" (Parent Interview #10). The formal division of labor may be clear to the workers, but can be confusing and overwhelming to parents. Frequently parents were either unaware of, or could not distinguish, between the different levels of pediatric personnel. When parents are uncertain regarding the identity and position of staff they are limited in their ability to properly utilize the staff or to direct their concerns to appropriate staff members.

The work that is done is also divided along informal lines based on personal preferences and abilities, or peer group pressure. Some nursing staff differ in their preference in terms of types of patient illnesses with which they feel most comfortable and competent in working with. As one nurse said, "I usually work with children who have cardiac conditions, I know the procedures and what is going to happen and I can talk with them and the parents and answer their questions and I feel really comfortable with it" (Staff Interview #3). Nursing staff also differ in their ability and skill in working with parents. Some staff are called on for their expertise in dealing with a family who is presenting a problem. "My contact with parents is mainly as a trouble shooter, the staff tell me when there is a particularly difficult situation that needs to be dealt with" (Staff Interview #8). Often the staff nurses direct their problems with individual parents to the head nurse or clinical specialist who are considered to have expertise in these situations.

The informal division of labor is particulary relevant when considering the aspect of the staff working with parents of a hospitalized child. There is no set place in the formal structure of work when time is set asied to work with parents. How and when the individual staff interacts with parents is left to them. Individual staff have varying philosophical perspectives regarding working with parents. The particular parent orientation of the staff will influence the way they interact and/or work with parents.

Nurses with an inclusion orientation towards parents will make an effort to devote part of their time to working with parents. Those of a middle of the road orientation will work with individual parents with whom they feel comfortable, and tend to ignore others they consider to be problem parents. Staff who have an exclusion orientation towards parents will focus their work on the child, interacting only minimally with parents, considering them outside the realm of their job. In the situation where there are staff of differing orientations, the work of dealing with parents is taken up or relegated to those staff who enjoy or have the skills necessary to work with parents.

The type of nursing care organization also influences the informal division of labor. In team nursing a group of staff are responsible for a group of patients. It is therefore easier to shift the work of dealing with parents to one or certain of the team members and to provide care to patients and families despite

the existence of staff who have a parental exclusion orientation. In primary nursing, one nurse is responsible for several patients. In this situation there can be no shifting the work of dealing with parents on to other staff. It is the responsibility of that individual nurse to care for the patients as well as work with the parents. Therefore, the individual orientation of the primary nurse has a greater affect on the parents.

Peer group pressure can also have an influence on the informal division of labor. A sense of personal and professional identity comes from the feeling of belonging and being a part of the grou! with which one is working, and it is therefore difficult to maintain a position that differs greatly from the majority. The more cohesive the group the stronger the pressure on a group member who attempts to deviate from the group norms (Cartwright and Zander, 1968). If the majority of the staff on a particular unit are of an exclusion orientation nurses who have an inclusion orientation find it difficult to operationalize their philosophy in dealing with parents because of the lack of sanction and support of the group. Acceptance by peers whom one has to work with everyday assumes greater importance than satisfaction from isolated incidents of working with parents who are transient in the system.

The work of the staff in caring for and treating the patient is for the most part organized along formal lines. However, the work of dealing with family members of the hospitalized patient is organized along informal lines based on staff orientation, preferences, skills, and peer group pressures.

The parents moving into the hospital system must learn both the formal and the informal structure of work in order to determine their place in the division of labor and manage their role. It is the formal structure of work that becomes more quickly apparent, such as shift changes, the times of physician rounds and nursing reports, and the times of baths and feedings. The informal structure is less patterned and more difficult to grasp because it is related to individual staff orientation, skill and preferences. In order for the parents to get a handle on the informal structure, it is necessary for them to spend time in the setting. When they are present in the setting they begin to get to know the various staff members and it becomes easier for them to determine the individual orientation of the staff towards them. They can then select among the staff present those with whom they feel are more open towards parents and parental inclusion in care and negotiate their role in the setting.

Division of Labor: Staffing Consistency

The dimension of staffing consistency is relevant in terms of the division of labor on the pediatric unit. This dimension includes the continuity of assignment of particular staff to specific patients and the consistency of persons who are present and working on the pediatric unit.

A child's care may be delegated to a nurse who consistently cares for the child on her shift during his entire hospitalization.

Many nurses preferred this as it gave them a chance to get to know the child and his family and establish a rapport with them. However, most often the child will have several nurses who are responsible for his care at different times. A nurse may at times request a change of patients because of the intensity of the care required or a clash of personality with the child or the family. Nurses also have days off, breaking up the consistency of care. They may return after their days off to be assigned to a different group of patients. They must then begin again to get to know the patient and family.

Nurses and house officers state they get to know best those patients they care for or are directly responsible for. They may be aware of all the patients on the unit at a given time but have extensive knowledge only about those children and families they are caring for directly. Chronically ill patients and their families become known to all of the staff during their repeated admissions because of time and exposure and the possibility that more and more staff will be directly involved with their care. Parents of these children also come to know more of the staff.

House officers spend a specified time in the in-patient pediatric unit. They rotate approximately every six weeks. Therefore the medical personnel a parent has to deal with can vary either during a single admission or at repeated admissions.

Parents are forced to deal with and relate to a variety of staff persons during the period their child is hospitalized. The greater the consistency of the staff, the greater the possibility that the parents can assume and/or negotiate a role for themselves in the care of their child that is agreed upon by them and the staff. When staffing consistency is lacking parents must more frequently deal with new and unfamiliar persons, adjust to persons with possibly differing orientations, and constantly re-negotiate with the staff regarding their role and place in the setting.

The times of the day and the days of the week affect the structure of the work and the division of labor. The day shift during the week is ordinarily staffed with the greatest number and variety of health professionals, not only nursing and medical staff but also interdisciplinary personnel such as social workers and recreational therapists. Week-end staff, and evening and night shift staff are reduced in number and also in interdisciplinary personnel. This reduction in numbers and variety of personnel may increase the work load for those staff who are working. This in turn decreases the parents accessibility to staff or to staff persons with whom they are familiar or have established a rapport. As one father said, "If the doctor [house officer] assigned to your child isn't on the weekend you just have to wait till Monday morning to get anything done" (Parent Interview #7).

Consistency of numbers and levels of personnel available varies with the time of day and the day of the week. This variation

affects the way the work is divided and the priorities that staff set with regard to the work to be done, and the staff persons with whom parents interact.

Division of Labor: Ward Work, Medical Work, and Parenting

An analytical differentiation is made in this study regarding the kind of work done in the pediatric unit, in distinguishing between ward work and medical work and parenting. Ward work refers to the routines of the day and includes all the things that are done to maintain ward order and facilitate the medical work. These activities are not specific to a particular child but encompass all the patients. Some examples of ward work are; shift to shift patient reports, patient rounds, charting, ordering and maintaining the supplies needed to provide patient care, the activities of daily living such as bathing, and feeding the children and maintaining a clean environment. All of these activites are routine practice in the hospital setting. They are the basic functions that create the environmental set within which medical work takes place. Some aspects of ward work, such as bathing, changing and feeding the child can be the shared activity of the pediatric staff and the parents.

Medical work encompasses all of the treatments, procedures and care that are specifically related to an individual child's illness or disease including such activities as the administration of medications, intravenous therapy, diagnostic procedures and

treatments, surgical procedures, pulmonary therapy, dressing changes. Medical work is considered primarily the territory of the health professional who has the knowledge, skill or training to perform these functions.

Parenting, on the other hand, is seen as distinct from both ward work and medical work, and is viewed as primarily the responsibility and territory of the parent. The parent qualifies for these functions by virtue of his position and role as mother or father of the child.

Parents interviewed in this study related that certain aspect of normal parental functioning and responsibilities are heightened by the hospitalization of the child. Nurturing, protecting and maintaining the parent-child relationship were the functions of parenting considered important by the parents in this study and as comprising part of their role and identity in the hospital setting.

Nurturing refers to the parental function of providing emotional and psychological support for the child. It involves the dimensions of loving, caring and concern. Parents frequently related their need to spend time in the hospital with their child in order to let the child know he was loved and cared for. Therefore, parental accessibility to the child facilitates the performance of the nurturing function.

The functions of protecting includes the parent's protection of the child, as well as protection of their own identity as parents. Parents feel responsible for safeguarding or defending the child from unnecessary harm, pain or trauma. In this study the parents interviewed were parents of children four years and younger. It was the inability of the child to protect himself that heightened this responsibility in the parent. The majority of parents are willing to comply with the recommended medical treatment plan for the child. They are, however, unwilling to allow the child to be subjected to pain or trauma that they believe to be unnecessary.

When the staff orientation towards parents is one of inclusion, and humanistic care is given the child by the staff, the parents trust in the staff increases and their need to "watch over" and protect the child lessens.

Protecting also refers to the parent's self-protection and defense of their own identity as a parent. The parents interviewed related their need to be recognized and acknowledged as being the child's mother and father rather than being treated as just another anonymous visitor. It was observed that the more acknowledgment given parents by the staff, the less was their need to make demands on the staff in order to aggressively assert their parental identity. The staff acknowledges the parent by addressing them by name, seeking relevant information from them regarding the child, providing information to them abut the child and his condition, and involving them in the planning and giving of care to the child.

The thrid function of parenting that the parents in this study perceived as their responsibility was that of maintaining the parent-child relationship. The family unit is considered a system and the primary function of a system is to maintain itself (Hall and Fagen, 1956). Parents in this study related that being with and spending time with the child was necessary in order to give the child what they felt no one else could and that is, parental comfort and support and a sense of belonging and identity. The maintenance of the parent-child relationship was considered to be not only a benefit to the child but afforded the parents the opportunity to "perform" as a parent and do the best they could for the child in the situation. Performing their role as a parent, that is being with the child and supporting them through the experiences of the hospitalization, despite their natural reluctance at times to see the child in pain or discomfort, resulted in a snes of accomplishment for them and a sense of fulfillment of their personal responsibility as a parent toward their child.

Whether or not the parent is included in the division of labor with regard to ward work or medical work depends on both the staff and the parent. The staff's orientation towards parents dictates to a large degree the extent to which the staff is willing to include the parent in the division of labor. The majority of the staff in this study expected the parents to spend some time with the child, and to comfort and be of support to him, that is to "parent."

When the parent was considered a "visitor," and the staff orientation was one of exclusion the parents were not expected to participate in either the ward work or the medical work. They were in fact, seldom allowed to. Nurses with an exclusion orientation found it difficult to give up aspects of medical or ward work considering these aspects of care to be their territory, their work, and their responsibility. They viewed parental presence during the giving of care as a hindrance to their getting the work done. Parents under these conditions either restricted their activities to the parenting functions, leaving the actual giving of the child's care to the staff, or they negotiated to have a share in giving care to the child. However the negotiations with staff of this orientation were often unsuccessful as the staff utilized their position of power, and the rules and policies, in order to maintain the boundaries separating the work of the professional and the functions of the non-professional.

Nurses with a middle of the road orientation vacilate in allowing parents a share in the ward or medical work, and do so based on their assessment of the individual parent's willingness to participate, plus their own need at a given time to claim a certain aspect of care as their territory. Nurses with a middle of the road orientation most often perceive the infliction of necessary pain, such as the performance of treatments or diagnostic tests, as their territory and the responsibility of the health professional. They view

parental presence in these situations as a hindrance to their work, and therefore suggest, and/or coerce parents to absent themselves from them.

Staff with a middle of the road orientation often shift in their willingness to allow parents to share in the giving of care depending on the time available to them in relation to the work to be done. The less time available to the staff to accomplish their work the more they are apt to encourage the parent to participate in giving care such as feeding, changing or bathing the child.

The difficulty for parents dealing with staff who have a middle of the road orientation is the fact that they do vary from simply tolerating the parent to accepting and involving the parent. The parent under these conditions must then work to gain the trust and confidence of the staff and prove their ability to share in providing the necessary care for the child. Nurses with a middle of the road orientation are amenable to parental negotiation regarding a share in the work but most often wait for the parent to initiate such negotiation.

Nurses with an inclusion orientation toward parents actively foster parental sharing in the ward and medical work. They encourage and assist parents to participate taking into consideration the parent's desire and ability to do so. They claim only the highly technical aspect of care as their territory and even in these

instances include the parent on a intellectual level if not a performance level, by explaining to them what is being done. Staff with this orientation assume the parents want to participate in the care and often initiate negotiation with the parent in an effort to facilitate their involvement in care.

Nurses of an inclusion orientation most often take the time to assess and discuss with the individual parent their desire to participate in the giving of care. However, if they attempt to impose their beliefs regarding parental inclusion on the parent who is otherwise inclined, conflict regarding role performance results. That is, a parent does at times feel comfortable performing only the parenting functions of nurturing, protecting and maintaining the parent-child relationship, thereby facilitating the ward and medical work of the staff, rather than participating in the actual giving of care. In these situations parents are content to allow the staff to give the care and their need for inclusion relates to being kept informed regarding the child's condition. Unless the staff are willing to go along with this particular parental perception of inclusion, attempts of the staff to coerce parents into giving care can result in making the parents feel that they are shirking their responsibility.

Not only do staff differ in their willingness to share the medical or ward work with parents, but parents of the hospitalized child also vary in their <u>desire</u>, <u>knowledge</u> and the <u>skill</u> required

to be included in the medical and ward work. This in turn affects the structure of the work.

The parents in this study can be differentiated into three groups according to their desire to participate in the ward or medical work. The first group did not want to participate in the work. They remained on the periphery and were content to have the staff give the care to the child, making such comments as "whatever they do is fine, they know what to do" (Parent Interview #13). They saw their role as visiting the child and providing comfort and support. The second group desired to participate in the ward work such as bathing, changing and feeding the child, leaving the more technical aspects of medical work to the staff. The third group were those parents who desired a highly active participatory role in both the ward and medical work. Parents in this group were most often those whose child was chronically ill.

The parent's knowledge of the work to be done and what they themselves can do also varies. Their experience with hospitalization and the child's illness is a factor influencing their knowledge level. Parents whose child is admitted for the first time are less knowledgeable regarding the illness and the care required. They are also more hesitant to assume a place in the division of labor. Parents of chronically ill children have more knowledge of the disease and the child's care. They are also more knowledgeable

regarding the hospital and the structure of work and therefore more assertive in making a place for themselves in the division of labor. The more information regarding the child's condition and care and the parent's place in the share of the work that a parent receives, the greater is his knowledge level. The greater the knowledge level, the easier it is for parents to negotiate their role.

Parents of the hospitalized child differ in their possession of the skills required to become involved in the ward or medical work. Their skill in the giving of care is influenced by their experience with a particular illness and with hospitalization, and the amount of information they receive regarding the care that is required. Most parents have the skill to participate in ward work, but often hesitate to do things that they consider medical work.

Another factor influencing parental participation in ward or medical work is family and personal responsibilities of the parent outside the hospital setting. These responsibilities are influential with regard to whether the parent is able to spend time in the setting in order to participate in giving care to the child. For example, some parents in this study were working and therefore their time spent in the setting was more limited.

In terms of the hospital organization, it could be considered more efficient for the overall structure of work to exclude parents from the division of labor. The staff are a known quantity

in terms of numbers and job responsibilities, and a known quality in terms of their individual capabilities and skills. The parent, however, is an unknown quantity that is, which parents and how many will be present at any given time is not certain, and they are an unknown quality in terms of their individual desire, knowledge and skill necessary to participate in the work to be done. It is easier and more efficient to plan the work to be done if it is based on known quality and quantity.

Staff with an exclusion orientation justify the maintenance of strict territorial boundaries between the professional and the non-professional and the exclusion of parents from a share in the work on the basis of efficiency. On the other hand staff who have a parental inclusion orientation do not deny the decreased efficiency, however, balancing the risks and benefits to the hospitalized child they are willing to loosen the territorial boundaries and allow the parents a share in the work of caring for the sick child.

The Time Factor

Temporal aspects are highly relevant and influential in terms of how the work of the staff is structured and divided. Staff frequently refer to the problem of limited time in which to do everything that needs to be done. They see the care of the sick child as their primary responsibility and main work. Often

due to pressure of time and the medical needs of the sick child, parents are relegated to the sidelines or given a lesser priority, despite a middle of the road or inclusion orientation towards parents.

Under the conditions where the staff "have the time" they interact and spend time with the parents depending on their parental orientation and whether they perceive dealing with the parents as part of their work or as "extra" and above and beyond their work responsibility. If parents are perceived as "extra," interaction between staff and parents is minimal and parents are often ignored. Demands by parents for staff time are viewed by the staff as interferring with the work to be done. When parents are viewed as part of the work of the staff, the staff takes the time, to the best of their ability given the situation, to interact with the parents.

Based on observations of parent-staff interaction and staff interviews, parents can be termed as either in-patient parents or self-care parents with respect to their need in the hospital setting and the time required of the staff. An in-patient parent is perceived by the staff as being within the scope of their work but is one who requires a great deal of nursing time. These parents are often highly anxious or openly hostile, which restricts their ability to give support and help to their child. They are themselves in need of care, time and support from the staff.

They can become the "problem" parents to the staff because of the amount of time required to deal satisfactorily with them and their concerns which in turn often limits the time staff can then devote to the patients. Although the staff are willing and do spend time with these parents they are often frustrated in their efforts because the concerns of the parents are such that more time is needed than the staff can realistically devote to meeting.

The term self-care parent is applied to parents who require nursing time not to meet their own needs, but to help them work through the hospitalization so that they in turn can help the child. They are able to identify their needs in the setting and to solicit appropriate assistance from the staff. These parents are perceived to be within the scope of work of the staff but need less active attention from them and are able to work with the staff in caring for the child.

The operationalization of a parental inclusion orientation is directly related to time availability. The more time that is available the better able the staff is to perform their primary function of caring for the child and still have time to spend interacting with parents, answering their questions, explaining treatments and procedures to them and generally determining how the parents are handling the experience of the child's hospitalization. If time is lacking the frustration level of these staff increases because they are unable to put into practice their philosophy of family care.

Having the staff spend time with them is symbolically significant to the parents and makes them feel "a part of it all" and "important," thereby serving to foster their self-identity as parents and necessary persons in the care of the child. The more time a parent spends in the setting the greater their awareness and understanding of the formal and informal structure of the work. This understanding increases their level of knowledge and their ability to negotiate a place for themselves in the care of the child.

The factor of time affects not only the staff but also the parents of the hospitalized child. The time available to staff affects the priorities they set up with regard to the work to be done. The time parents spend in the setting is influential in terms of their knowledge of the structure of the work and their inclusion in the division of labor.

Section III

Balance of Power

Balance of power refers to the control aspects of a situation, that is, what person or persons have the right and authority to influence or control others and to direct what occurs in a given situation. The dimensions of power relevant to this study that will be explored are: bases and types of power; levels of power; and threat to power: the risk/benefit factor.

Bases and Types of Power

Power has been defined as "the ability of one person or group to influence the behavior of others" (Kaplan, 1964, p. 12). From this definition it is clear that at least two persons are necessary for power to exist. A person has power because of his position in a social relationship to another. Emerson (1962) emphasizes this relational aspect when he states, "power resides implicitly in the others dependency" (p. 32).

Emerson (1962) further states that a person has power to influence another because of his control over that which the other person values. This dimension of the bases of power is particularly relevant in referring to a parent and his child. The child is not an inanimate object needing repair, but a valued person and member of a family.

The parent has a strong emotional investment and a socially ascribed as well as a personally accepted responsibility concerning the health and well-being of the child. When the child has a minor illness and is at home this parental responsibility and concern results in action to care for the child. If the illness progresses to a stage that the parent no longer has the knowledge and skill to deal with it their anxiety and concern is heightened. When the child is admitted to the hospital the emotional involvement of the parent becomes separated from the responsibility for management in the area of the child's medical treatment. Feeling is separated from action, and control over the medical management of the child is ceded to the health professional. This places the parent in a position of dependency on the health professional which can be a source of trust and/or anxiety for the parent. The parent is further dependent in that once the child is hospitalized alternative avenues for goal achievement of health for the child are limited. It is the action and health care management of specific health professionals in that setting that the parent must rely on.

The combination of high value of the child to the parent, plus parental dependency on the health professionals, places the parent in a less powerful or "one-down" position in relation to the health professional. Watzlawick et al (1967) describes what he calls, "complementary relationships." These relationships are based on the maximization of differences that is, one person

is in some way superior or "one-up," whereas the other person is in some way inferior or "one-down." He makes the point that moral implications of good or bad, strong or weak are not intended, but that in a complementary relationship, behavior of the two individuals is fitted, albeit different, and evokes corresponding behaviors in the other in an interlocking relationship (Watzlawick et al, 1967). The health professional and the family unit are in a complimentary relationship. The behavior of the health professional evokes corresponding behavior on the part of the non-professional.

Haley (1969) refers to any relationship in which one or the other person maneuvers to achieve a "one-up" position to gain some control and power. A relationship is constantly defined and re-defined depending on the on-going circumstances. For instance the parent of a chronically ill child may believe himself to be more knowledgeable in regards to his child's illness and care than a house officer or nurse, and therefore will challenge the power and control of the professional and attempt to gain a "one-up" position in relation to them. On the whole, however, within the hospital setting the parent as a non-professional is considered "one-down" in relation to the knowledge and skill of the health professional.

The basis of power refers to the relationship between at least two individuals that is the source of that power. For this analysis three types of power relationships that were seen to

occur in the hospital setting are discussed; those relationships that form the bases for "legitimate power," "expert power," and "reward and coercive power" (French and Raven, 1968; Katz and Kahn, 1966).

"Legitimate power" is based on either cultural values, acceptance of a social structure, or designation by a legitimizing agent (French and Raven, 1968). Katz and Kahn (1966) define legitimate power as the perception of one individual that another has a legitimate right to perscribe behavior for him. In our society cultural values are such that a patient ordinarily accepts a physician's legitimate authority over him. The parent accepts as legitimate, the authority and right of the physician over the sick child. Parental acceptance of the legitimate power of the physician is expressed by the comments of parents. "You don't have any say as far as the treatment for the child is concerned, because it's all so basic and has to be done" (Parent Interview #3).

Within the social structure of the hospital setting the employed health professionals are also accepted as having legitimate authority and are designated by the hospital administration as being in positions of authority in relation to the patients and families. They have authority to assist in planning and carrying out th- treatment plan for the child. As one parent stated, "It's the nurses job to carry out the doctors orders. That's their

work" (Parent Interview #8).

The legitimate authority of the health professionals is sanctioned by cultural values and the hospital system and extends to the child, who is the patient, in terms of medical treatment and care, and to the parent who is present in the hospital setting.

The parents also have culturally sanctioned legitimate authority over the child by virtue of their position as parents. Legally they must give consent for the child to be treated. Once consent is given parents share their legitimate authority over the child with the health professionals with respect to medical management and treatment. Because the legitimate authority of the parent is recognized by the staff, the presence of the child's parent does influence and to some extent control staff behavior. Although parents have no authority to dictate the work to be done by the staff, their presence serves to alter the situation in which the professional has complete control over events that occur with no one to account to but themselves and other professionals. Parental presence increases staff accountability to the parent.

"Expert power" is based on the extent of knowledge and ability one person perceives the other to possess (French and Raven, 1968). In this study power is closely related to legitimate power. The health professional who has legitimate power because of his position in the system attains that position based on his knowledge and skill. Although parents expect physicians and nurses to be knowledgeable and skilled, they do not necessarily grant this

expert power carte blanche but assess the individual health professional. Parents assess the manner in which the health professional performs their work. The more knowledgeable and skilled they appear, the greater their ability to answer parents questions, and the greater their skill in providing humanistic care to the child the higher the level of trust the parent has in the staff.

Parents also possess varying degrees of expert power in relation to the sick child. The more naive the parent the less expert power he possesses. The knowledgeable parent whose child is chronically ill has most often attained a certain degree of knowledge and ability regarding the child's illness and care. However, parents may or may not be credited by the staff as possessing the necessary skill and knowledge to care for the child. The greater the power and control needs of the health professional the less the expert power of the parent is acknowledged. Also the more critical the child's condition and the higher the level of technical care needed to care for the child the less expert power the parent has in relation to the health professional.

"Reward and coercive power" forms the bases of a relationship in which one person perceives the other as being able to reward him for his behavior or punish him for his non-conformance (French and Raven, 1968). The strength of this type of power lies in the value attributed to the reward and the desire to avoid or deter punishment.

The staff is in a position to mediate rewards and/or punishments to the child and to the parent. According to the parents in this study the rewards valued are skilled treatment of the child and caring and concern on the part of the staff for the child, and for themselves. The punishment feared is decreased care and attention to the child, exclusion of the parent from information regarding the child's care or decreased accessibility to the child. The parents were aware of the punishment power of the staff. They stated that as a result they refrained on occasion from "bugging" the staff with questions, or "interfering with their work," or generally becoming what might be considered a "trouble maker." As one mother said, "A couple of nurses resented my asking them questions or reminding them to do things. So sometimes I didn't say anything. I was afraid they'd get upset and them I would be punished and they would ignore me even more" (Parent Interview #21).

The parent is also in a position to reward or punish the staff. Parents reward staff by trusting them to care for their child. As one mother said, "He's in good hands here. We never felt uncomfortable about leaving him here at all" (Parent Interview #5). Parents also have the power to punish the staff. Parents who criticize and continually question what the staff is doing give the staff the impression that the parent is uncertain of the staff's ability and competence to care for their child. Parents can and do complain about the care given to their child, refuse treatment or in some cases threaten to sue the hospital.

With regard to punishment or coercive power both staff and parents have what can be termed an "ace in the hole." The use of the "ace in the hole" represents a powerful threat because it is aimed at the core of professional or parental identity. Staff can and do restrict parental access to the child, or banish the parents by evoking rules or using the rationalization that it would be better for the child if the parent was not present. Staff can provide only the necessary "technical care" for the child, give minimal attention to the parents, or restrict information to parents regarding their child's condition. The parent on the other hand can report the staff or complain to higher authority such as the attending or private physician or hospital administration thus putting the staff's job in jeopardy. Parents can also refuse medical treatment, removing the child from the hospital or threaten to sue.

Levels of Power

The hospital system is based on a hierarchical structure, that is, power is greatest at the top and lessens in the subsequent lower positions. The type of power the health professional possesses is sanctioned by the hospital system and medical practice. The hospital system maintains control by establishing policies and rules.

The knowledgeable parent possesses a greater awareness of the structural hierarchy in the system and is able to distinguish the various levels of nursing and medical personnel and therefore

utilizes the existing hierarchy in attempting to negotiate a change in the child's treatment and care, or their place and control in the setting. Based on their experience in the setting the knowledgeable parents are able to single out specific individuals who are able to exert influence to bring about change. As one father related, "You get to know who is who and who you can go to if you want to get something done" (Parent Interview #11).

The naive parent is less experienced with the hospital structure and the various professional levels of the staff. These parents ask their questions of, and concentrate their negotiating efforts, either on the staff persons with whom they are in most frequent contact, regardless of their level in the hierarchical structure, or they take their concerns only to the attending or private physician. This latter tactic limits the negotiating possibilities for these parents.

The health professional also recognizes and respects this hierarchical structure in terms of exercising power and authority. Major decisions regarding medical treatment of the child as a patient are seen as being within the realm of action of the physician or house officer. Nursing staff carry out the treatment planned, making decisions regarding the way the care will be given and by whom. The staff are also the enforcers of hospital rules and policies. Parental behavior in the setting and the amount of parental involvement in the work of caring for the sick child

are controlled to a large degree by the nursing staff. The orientation of the staff towards parents has a affect on their willingness to share power and control with the parents. The greater the exclusion orientation, the more strict the territorial boundaries between the professional and the non-professional and the more forceful staff are in attempting to control parental behavior.

Threat to Power: The Risk/Benefit Factor

The agents of control within the hospital system are the health professionals who have authority by virtue of their position in the system. They attempt to maintain the orderly functioning of the pediatric unit so that care for the sick child can be provided in the most effective and efficient manner.

A parent can attempt to exercise power in an area within which he has no legitimate or expert authority. This can create a conflict situation where there is a discrepancy between individual needs and organizational requirements, and constitute a threat to the power position of the health professional. Parents however hesitate to threaten the system or challenge the authority of the staff, and make such comments as, "I don't want to seem like a rebellious mother," or "I don't want to be a problem parent." Several parents related that they feared reprisals either for their child or themselves if they criticized or attempted to interfere with the staff. They also recognize and accept the "one-up"

position of the health professional saying, "after all I'm not a doctor or a nurse."

The parent weighs the risk he would take in being critical or interfering, against the benefits that may accrue. A parent may take the risk when he balances personal feelings and identity with the child's needs. The balance shifts when his tolerance limit is reached regarding what is happening to the child. He may not be satisfied that his child is receiving the best treatment possible. This will then tip the scales so that the child's needs, as he perceives them, are the priority, and he will risk personal rejection in order to force the issue of better care for his child. "I don't care what they think about me, it's my child's care that is important" (Parent Interview #9).

Parens whose child is chronically ill become more knowledgeable in terms of medical care related to the illness and therefore perceive themselves to be on a more equal basis in relation to the health professiona, "I feel I know just about as much as they do about her care" (Parent Interview #3). This experience and knowledge provides the basis for a shift in the risk/benefit aspect of power and control. "I'm starting to learn to fight, to speak up more and not worry about what they think. I know a lot about his disease, sometimes a lot more than some of the staff and so I feel I should have a say in what they do" (Parent Interview #18).

The staff also weighs risks and benefits when exercising their power and control over the parents and the child. Their

primary concern is the progressive physical and emotional improvement of the child. They are therefore willing at times to decrease their control and allow the amount of parental control and involvement to be increased for the benefit of the child. Staff related how the increase in the amount of parental presence and visiting, that is the increased accessibility of the parent to the child, has had an effect on lessening trauma to the hospitalized child.

Parental presence can be a benefit to the child and to the staff in terms of getting the work done. Parents either actively assist the staff in caring for the child, or by giving the child emotional support, comfort and the security of their presence they facilitate the medical and ward work. On the other hand, increased parental presence also increases the possibility of parental threat to staff control. As one nurse said, "You can't always do things the way you want to when the parents are here" (Staff Interview #10). Therefore they vary presence of the parent serves as a control over the behavior of the staff.

Summary

The three kinds of relationships between the health professionals and the parents that form the bases of power have been described, as well as the scope and range of power and the threat to power. The power and control aspects of the hospital situation are important because of the value of the child to the parent, and their emotional investment in the goal of health for the child. Parents are

dependent to a large degree on the health professionals for the attainment of that goal.

The staff as health professionals have the advantage of sanctioned legitimate authority in the system and the support of greater numbers of persons on which to base the exercise of their power. The willingness of the staff to share control over the child with the parents is directly related to their parent orientation. The parent, as a non-professional, although having legitimate authority over the child may be lacking in expert power in many areas of the child's care. They are also one against many and therefore their ability to force a shift in the balance of power is often diffuse, limited and ineffective.

Section IV

Information Exchange

Information exchange refers to the giving and receiving of messages, and is viewed both as a means of communication and a means of control. The relevant dimensions of the category for this study include: the flow and direction of information, the kinds and sources of information, information disclosure and control, and temporal aspects.

The Flow and Direction of Information

The exchange of information is at the very heart of the hospital organization. Observation on any pediatric unit quickly validates the existence of a constant flow of information. Information exchange among health professionals, and between health professionals and the child and his family constitutes the basis upon which medical treatment and nursing care are given. Information regarding signs and symptoms of the sick child is gathered either by observation or through verbal communication. Diagnostic tests and procedures provide information necessary to the child's treatment. A patient and family history is taken on admission of the child and provides another source of information relevant to care. Parents are given information to a greater or lesser degree regarding the diagnosis, treatment and prognosis of their child.

Information giving and receiving constitutes a complex network involving a variety of persons in the setting. There is

no single means by which information is transmitted. Information can be transmitted through face to face exchange, or via the use of instruments and/or written material exchange.

Information exchange occurs in both structured and unstructured situations. The organization of work on the pediatric unit provides for structured situations within which information is given and received. Such situations include the shift to shift patient reports of the nursing staff, medical and nursing patient rounds, scheduled meetings and conferences, and the initial history taking of the child and parent done by the house officer and nursing staff. All of these instances involve face to face exchange. Other structured forms of information transmission which are written include daily notes in the patients chart, use of the patients kardex containing the plan of treatment and care. These structured conditions for information exchange provide specified lines or direction for information flow.

Because of the variety of persons involved in the information network, many situations of information exchange are unstructured with no uniform pattern or direction. Health professionals are "tracked down," "caught up with" or "run in to." Parents are often given information based on a "catch as catch can" basis. Information is exchanged during staff coffee breaks and meal times. Parents exchange information with other parents in the setting.

Spatially, the area or territory around the nursing station on the unit is the focal point where a great deal of information

exchange occurs. Parents quickly learn to "go to the desk" in order to give or retrieve information. The unit secretary stationed at the desk often becomes the pivotol person directing information flow.

The complex web and directional flow of information contributes to the possibility that information will be mis-directed, mis-placed, omitted or distorted, or that conflicting messages will be given or received. Also, because there are numerous persons from whom information may be retrieved, strategies and tactics are developed both by staff and parents to plug into the information network in order to give and/or receive information.

The Kinds and Sources of Information

The kinds of information required in the pediatric setting covers a wide variety of areas such as, information regarding the condition and treatment of patients, information about the structure of the work, information regarding regulatory rules and policies and information about the physical environment and use of space. Another kind of information is "meta-information," that is information about the information process itself, such as, how information is transmitted, from whom, where and when to get or give information.

The sources of information may be singular but most often are multiple. Examples of a singular source are: the attending or private physician who is the only one who has information regarding the discharge day of a child; a laboratory report giving information about a diagnostic procedure performed. Ordinarily, however,

several persons or places can provide the information sought. A nurse can receive information about a child's treatment from other nurses, the house officers, the chart or the parents. Because of the interdependency of the staff, most information is shared in a collaborative effort to provide care for the child.

On the other hand, multiple sources for the kind of information may exist, but only a singular source considered appropriate, accurate, or valid. Several staff may know the results of a laboratory test, but consider the physician the primary source of this kind of information for the parents. Nurses can be aware of a patients diagnosis or prognosis but are of one accord in believing that this information should originate from the physician to the parent. Parents frequently related their need to receive information about their child's condition from the "head or main man," that is, the attending or private physician.

Nursing staff get their information regarding the child and his family from multiple sources, such as shift reports, other nurses, rounds with house officers, informal interactions with other health professionals or the child and parent themselves. However, the number and variety of information sources available to nursing staff decreases in relation to the time of the day. The day shift affords the greatest opportunity for information retrieval. Nurses on the evening and night shift related often feeling isolated from the information network.

To whom a parent goes for information in the setting is related to their knowledge of the variety of information sources, and their trust in the credibility of the source. Physicians are generally credited by parents as being a reliable and pivotal source of information regarding the child's condition and treatment. The knowledgeable parent not only has a greater awareness of the variety of information sources and therefore seeks out numerous persons from who to retrieve information, but also becomes more selective based on their experience regarding which sources are the most accurate and knowledgeable.

Parent's knowledge of the sources of information is facilitated when the staff identifies themselves by name and states their position, that is, resident, intern, nurse in charge, or nurse taking care of your child today. Parents are bombarded by numerous individuals in various positions and knowledge of who is who in the setting is helpful to them in determining who m to go to for information.

Parents also utilize other non-professionals, that is, other parents in the setting with whom to share information regarding the staff, the unit, and the care given. The availability of other parents as a source of information is related to: the number of parents who spend time in the setting and the amount of time they spend, the number of experienced parents that are present, the similarity among parents with regard to ethnicity and language or the hospitalized child's illness, and the availability and use of a place where parents can congregate.

Staff are often apprehensive regarding such peer group sharing among non-professionals and hesitate to promote it believing that such sharing is often a source for misinformation. Parens however view their peers as not only a source of information but of comfort and support. Knowledgeable parents related their attempts to help the more naive parent to "understand what is happening," and were frequently observed to carry out what has been termed a "coaching" function. Parents feel that they are "all in the same boat" and therefore often find it easier to relate to each other with their questions than to the health professional who can be intimidating and who is frequently "too busy" to deal with their questions and concerns.

The kinds of information that are the most important to parents fall into two classes. First, verbal information that is specific and related to the child's illness and second, information relating to the attitude of the staff toward their child. This latter class of information is retrieved by parents in their observation of and interaction with the staff.

On admission, parents are primarily concerned with finding out what is wrong with the child, what is going to be done and how long the child will be in the hospital. They are often frustrated by and impatient with any delays in receiving this kind of information creating tension between the parents and staff. The frustration of the parent is the result of their non-professional status wherein they lack the knowledge to determine what is wrong with the child and

what can be done for him. The frustration level is heightened by what they may initially perceive to be questionable ability on the part of the health professionals, or tactics by the health professionals to exclude them from the information network. They have acknowledged the fact that as non-professionals their ability to deal with the child's illness is limited. The possibility that the health professional to whom they have entrusted their child is also unable to treat and or cure the condition heightens parental fear and frustration. In time parents come to realize that a diagnosis takes time, but relate that "the waiting and not knowing is the hardest part."

The second class of information is related to the attitude of the staff in caring for their child that is <u>how</u> the care is given. Parents want to feel that the staff "really care" and are interested by observing how the staff relates and interacts with their child and other children on the unit.

Being included in the information network and receiving information of the first class, that is factual information about the child and his condition is symbolically significant to parents in relation to how parents view the attitude of the staff and the quality of their "caring" for the child. As one mother so aptly stated, "If they didn't tell me what was going on I'd feel like they weren't taking care of my child. When they do tell you everything it makes you feel like they care and that something is being done" (Parent Interview #6). Being kept informed increases

the parent's trust and confidence in the health professional who is caring for their child and allows them to feel included, at least on an intellectual level, in the healing process.

Closely following these two kinds or classes of information parents feel is important, is information bearing on their role and functioning in the hospital. The source of information regarding the parental role and position may be direct, as in verbal contracts with the staff, or come in printed information. However, most often the source of this information is indirect such as, "seeing what other parents are doing," "playing it by ear," or getting subtle clues from the nursing staff.

Information Disclosure and Control

The dimension of disclosure refers to the amount and content of the information a person is willing to reveal. The majority of the nursing staff agree that it is the parent's "right" to be kept informed. They differ however with regard to who should do the informing and how much information should be revealed. These differences have their bases in: the individual staff members philosophy regarding information disclosure, their personal knowledge of specific information, and their skill in handling what may be difficul situations.

Each staff member has his own philosophy regarding giving information to parents. This philosophy regarding information disclosure varies from believing parents should be informed and

being personally willing to give information, to believing parents should be informed but considering others to be the source of the information and themselves as a go-between. The philosophy regarding information disclosure is also related to the parental orientation of the staff. The greater the inclusion orientation of the staff the less strict the territorial boundaries between professional and non-professional and the more willing the staff to include parents in the information network.

The amount and content of the information the staff shares with the parent is directly related to the amount of information the nurse herself possesses about a particular child and his condition. "I don't mind parents asking questions as long as I know what I'm talking about" (Staff Interview #1). The more information a nurse has and the more willing she is to give information to parents, the less hesitant she is to interact with the parents. Whereas the nurse who is limited in her information or unwilling to give information to parents will employ avoidance tactics to reduce the amount of parent-staff interaction.

Nurses vary in their skill of dealing with situations that may prove to be uncomfortable. Some nurses are fearful about how parents may respond to information, particularly information which is of a negative or possibly traumatic nature. In these situations, the parent is most often referred to the physician for information.

In disclosing information to parents the esoteric language of medicine is a factor contributing to the possibility of inaccurate parental interpretation. Parents vary in terms of their level of sophistication with regard to medical language and terminology. The terms used in hospital parlance can be foreign and unfamiliar to the inexperienced non-professional. As a result the health professional can use language that inhibits the parent from receiving a clear message about what is occurring. The use of medical terminology can at times also serve to maintain the medical mystique and the territorial boundaries between the health professional and the non-professional. Parents who spend more time in the hospital setting or who have chronically ill children are better able to penetrate this language barrier than those who have had little experience in the medical arena.

Another area of information disclosure is that which relates to parents receiving information about and first hand knowledge of treatments and procedures being performed on their child. A common occurrence on the pediatric unit is the performance of diagnostic and/or treatment procedures. These procedures can be uncomfortable and painful for the child. Being present during such procedures was considered a source of information by some parents in this study.

Staff differ in their willingness to allow parents to be with their child during a traumatic procedure depending on their parental orientation, their willingness to allow parents to share in the

ork, their philosophy regarding information disclosure, and their need to maintain territorial boundaries. Therefore parents are either given a choice or encouraged to remain out of the room during the procedure. In situations when parents and staff are of differing opinions regarding parental entry to procedures the parents will then attempt to negotiate entry. The staff either allows the parent access or uses the power of their position to deny them. If access is denied despite parental attempts at negotiation, the parent ordinarily accedes to the staff's wishes.

Parents vary in their need and ability to be present during procedures on their child. When given a choice most parents base their decision on their need to know what is happening, their assessment of their ability to "take it," their need to be with the child, and how they feel the child will react with them present and negotiate accordingly.

The giving and receiving of information has symbolic significance and implications. Watzlawick et al (1967) states, "One cannot not communicate" (p. 51), so that when parents are given minimal or no information they perceive a message in this lack of information and feel "left out," "in limbo," that they are "not important," and that "no one cares" about their child or them.

The main sources of information in the hospital setting are the medical and nursing staff. Because they possess the information that parents need, they are in positions of control regarding the amount and content of the information disclosed. Limited information

to parents acts as a deterrent to their ability to enter into the social world of the professionals and become involved in the care of their child, either on an intellectual or a performance level. On the other hand information and explanations from the staff to the parents regarding what is happening to their child and what their role is increases the parental knowledge base from which they can then negotiate entry into the system.

Temporal Aspects

Just as the time available to staff influences the structure of work, so too the time factor influences information exchange. Time is required to give and receive information. If time is limited to the staff, parents may become second in priority to the child. It may be more important to do for the child rather than explain to the parent what is being done. Explanations given to the parents may be brief and time for parents to ask questions limited. As one nurse related, "There are days when we just don't have time to explain everything in detail to the parents, and have to try and do it piece by piece when we get a minute" (Staff Interview #19).

The time of day is relevant in terms of the availability of information sources. Nurses working the evening and night shifts relate their decreased accessibility to information. Parents also have less recourse to specific persons on the evening and night shift, such as social workers, specific interns or residents, or the attending physician. Parents who are experienced in the

setting come to know that certain times are better than others for getting information and therefore plan their presence in the setting to coincide with these times.

The amount of time the parent is present in the setting affects how well the parents and staff get to know one another. The more familiar parents and staff are with each other, the more comfortable the staff is in disclosing information. Parents who spend more time in the setting were also found to be more sophisticated in their ability to approach the staff and retrieve information.

Summary

Information exchange on the pediatric unit is vital to the care and treatment of the sick child. The medical and nursing staff are the primary sources of information about the child's condition. Inclusion of parents into the information network varies and depends on a variety of factors such as the staff's philosophy regarding disclosure, the time available to staff, the staff's possession of specific knowledge and information, the time the parents psends in the setting and the parent's ability to retrieve information. All of the parents interviewed emphasized their need for information about their child. Receiving information is important to them not only in terms of the facts, but is also symbolically significant of the staff's attitude towards their child and them.

Chapter Summary

The focus of this chapter has been on the key categories of orientation, structure of work, balance of power, and information exchange that were found to exist in the setting and to be significantly related to the situational role management of parents as non-professionals in the hospital system. Although each category and its dimensions is presented separately, within the social world of the hospital they do not exist in isolation but are interdependent and interrelated. The orientation of staff persons towards parents influences the way they structure their work, their willingness to allow parents a share in the work, their need for control or ability to share control with the parent, and the amount of information given to parents. The structure of work in turn influences whether staff can put into practice their parent orientation and whether there is time allotted for information exchange with parents.

All of these key categories impinge on, influence and are related to, the processes parents utilize to mangae their role in the hospital situation. The following chapter elaborates the phases and implementing processes of situational role management.

CHAPTER V

SITUATIONAL ROLE MANAGEMENT: PHASES AND IMPLEMENTING PROCESSES

The basic social process discovered in this study is that of situational role management. Situational role management represents this researcher's conceptualization of the attempts on the part of the family as non-professionals, to enter into the domain of the health professionals and to determine their place and role within the hospital system.

The family and the hospital can each be considered a social system. The primary function of a system is to maintain itself. This has implications both for the family and the hospital.

The maintenance of the hospital system involves the establishment of social positions and relationships in a structured hierarchy, all of which endures despite changes in the occupants of these positions. The professionals who occupy positions within the hospital system have specific roles to play based on the expectations encumbent in their positions.

When a family member is hospitalized a part of the family system is temporarily incorporated into the hospital system. The patient has an accepted position and role within the system. The family on the other hand has no formal position within the system and therefore no specified role to play. In order to maintain the family system and preserve their identity and relationships

as family members, the family attempts to manage their roles in the setting in a way that allows them to perform their natural familial responsibilities and functions in a manner that is satisfying to them and beneficial to the patient.

Family roles and relationships are altered when one member of the family becomes ill. These roles are further altered when the sick person goes from the home to the hospital setting. Once in the hospital setting the family members, as non-professionals must learn what is expected of them by the health professionals. Brim (1968) refers to this role-learning through interaction with others as the process of socialization. Socialization is not restricted to childhood but occurs throughout the life cycle. As Scott (1970) states, "Every new personal relationship entered and every group or organization joined, may be viewed as a socialization context, providing new roles to be played and new expectations to serve as guidelines for behavior and attitudes" (p. 156). The greater the conformity of family behavior to the expectations of the health professionals for them in the setting, the greater the degree of family socialization that can be said to have occurred.

Therefore in order to learn what their role is in a particular hospital setting, the family members interact with others in the setting, determine the expectations others have of them, and consequently manage their role within the situation. Existing factors in the setting are influential in the process of situational role management. The factors found to be relevant in this study

were the orientation of the hospital, unit and staff towards the family, the manner in which the work of caring for the patient was structured, the balance of power and control between the professional and the non-professional, and the network of information exchange. These factors constitute on-going realities the family encounters when they enter the social world of the health professional in the hospital setting.

Situational role management is being proposed as a framework within which to view the behavior of parents, who as family members and non-professionals are atempting to determine their role in the hospital setting.

The process of situational role management is comprised of three phases, that of parent-setting stress, parent-setting conflict, and parent-setting fit. Within each of these phases are corresponding implementing processes of defining/re-defining, balancing/negotiating, and settling. Implementing processes are those means employed by parents to manage their role in the situation within a particular phase.

For the purpose of clarity and ease of presentation the phases of situational role management are presented in what may appear to be a linear model. In reality however, parents do not situationally manage their role in a set way or in a lock-step fashion nor do they necessarily remain fixed in a given phase. The phase of parent-setting stress can be said to constitute the initial phase of situational role management for all parents. However, from

that phase parents may move either into parent-setting conflict or into parent-setting fit.

Section I

Phase of Parent-Setting Stress: Defining/Re-defining

The phase of parent-setting stress occurs in the initial period of hospitalization and, depending on events that take place, parents may remain in or re-enter this phase at any time throughout the hospitalization of the child. Stress is being defined in this study as the result of any conditon or situation that evokes ambuguity and uncertainty. The conditions or situations resulting in stress are non-specific, so that a variety of conditons and situations can produce the effect of stress.

During this phase parents are faced with much that is unknown and unfamiliar. It is a period when things are unsettled and vague. The implications of what is happening to their child and to them are unclear. They are uncertain regarding their child's condition, their role, and the role of the health professional and the surrounding physical environment.

In an effort to decrease the stress, clarify the situation and begin to manage their role, parents utilize the implementing process of defining. Through defining, the parent gives meaning to the situation.

Defining/Re-defining

The initial implementing process of situational role management is that of defining. This is an intrapersonal process of interpretation, whereby an individual gives meaning to a situation and interprets

the behavior and actions of others in that situation. This self-interpretation and meaning serves to guide his actions and response in that situation (Blumer, 1969). According to Mead (1934) man does not simply react to stimuli, but has the unique human attribute of interpreting stimuli and giving meaning to the action of others. This interpretation then guides his response. W.I. Thomas (1967) is credited for the term, "the definition of the situation," which he explains as the inital stage of self-examination and deliberation prior to any self-determined behavioral act of an indiviaul. Blumer (1969) elaborates on this concept and states,

> The human being makes indications to himself...his action is constructed or built up instead of being a mere release. Whatever the action in which he is engaged, the human individual proceeds by pointing out to himself the divergent things which have to be taken into account in the course of his action. He has to note what he wants to do and how he is to do it; he has to point out to himself the various conditions which may be instrumental to his action and those which may obstruct his action; he has to take account of the demands, the expectations, the prohibitions, and the threats as they may arise in the situation in which he is acting. His action is built up step by step through a process of such self-indication. (p. 81)

Areas of Definition

Although defining of the situation is an on-going process throughout the hospitalization, the initial definition by parents provides set for their behavior. This situational definition encompasses the child, the others in the setting, themselves as parents, and the hospital environment. Put another way, parents ask themselves, what is wrong with the child and what does it mean?

Who are all these people here and what do they do? Who am I in all of this and where do I fit? What is this place called the hospital?

The primary area requiring parental definition is related to the child, his current state of health, the treatment that will be required, the type of care provided him by the staff and the expected length of his hospitalization. The amount of time a parent has to prepare for an admission of their child to the hospital influences the defining process.

Parents whose child's admission is scheduled and expected come into the setting with some aspects of the situation already defined, such as the reason for admission and the treatment required. However, the manner in which the staff will care for the child is an area of uncertainty that can and does give rise to stress.

When a child is admitted suddently such as with an accident, acute illness, or an exacerbation episode, the parents are unprepared for the admission. The primary concern of these parents relates to what is wrong with the child and whether or not he can be helped. Uncertainty concerning the child's conditon with an unexpected admission results in stress for the naive as well as the knowledgeable parent. However, the level of uncertainty was observed to be less in the knowledgeable parent due to their history of experience with the child's illness.

In their attempts to define the situation in relation to the condition of the child, the parent as a non-professional depends on

input and information from the health professional. Even the more knowledgeable parent seeks out information from the staff in order to validate their definition of the child's current state of health.

The illness and hospitalization of a family member alters existing roles and relationships. The diagnosis of the child's condition has an impact on the parent's self-identity. If the child is being admitted for a condition that is temporary, and can be alleviated with medical treatment and/or surgery, th- expected illness trajectory of the child is limited to a designated time table. The parent is then parent of a temporarily ill child. If the child is diagnosed with a chronic or life-threatening disease that parent is not longer a parent of a well child, and must undergo a re-defining process which, because of the child's state of health, alters their definition of themselves as parents in relation to that child. They become parents of a sick child.

The next aspect of the definition of the situation relates to the staff members and their position in the setting. Parents want to know who is going to be involved in caring for their child. The health professionals can take the initiative and introduce themselves to the parents by name, stating their position and role in relation to the child. This reduces the uncertainty on the part of the parents and allows them to seek out appropriate health professionals with whom to interact.

In situations where the staff do not identify themselves the parents are left on their own to distinguish the various levels of personnel and their place within the hierarchy. In an attempt to do this parents were observed to search for name tags on personnel, observe the staff as they work taking into account events that occurred when certain staff were around, "pick it up" by listening to others, or question one staff member about other staff in the setting. Knowledge of who the various persons in the setting are and their responsibilities in relations to the child allows the parent a more complete definition of the situation.

Part of the parent's definition of the situation with regard to the staff relates to the concern about whether the staff will "really care" about their child, or whether they will treat the child like "just another case." Parents observe how the staff relates to and cares for their child and other children in the setting. They assess the staff according to their perception of the technical competence of the staff combined with their ability to give humanistic care to the child. The greater the perceived level of competence and humanistic caring by the staff, the more apt parents are to define the particular hospital as a "good place" for the sick child to be.

On admission parents are attempting to define their role and position in the setting. Most parents related feelings of "helplessness," not knowing what to do or what was expected of them on the initial admission of the child. Not only are they

unsure of what is wrong with the child or what will be happening to him, there is an uncertainty with regard to what they can, should, or will be allowed to do. They are concerned about the degree of accessibility to the child, that is, what the visiting hours are and when they can be with the child in order to maintain the parent-child relationship.

Prior to hospitalization the parent has a relatively well-defined parental role and functions accordingly. On admission they are faced with a new situation, that is, the altered state of health of the child and the strange environment of the hospital. It is within these conditons that the parents attemtp to define their role and functions. The ability to perform roles adequately fosters self-identity and a feeling of self-satisfaction.

When the parent comes to the hospital he remains a parent but may be forced or persuaded to give up certain familial functions of that role, such as, nurturing, protecting, maintaining the parent-child relationship. Although his identity as parent remains unchanged, what may be altered is his ability to function as a parent. This in turn lessens confidence in self, which in fact may be already lessened by guilt over the fact that the child is sick in the first place. The onset of sickness and hospitalization of the child was frequently viewed by the parents as the result of inadequacy on their part. The lack of a specified position and role for them in the setting limits their ability to function as a parent and further increases their feelings of inadequacy.

The hospital environment itself has an impact on the parent's definition of the situation. Naive parents feel like they are in a strange and foreign world and describe the hospital as a "giant machine." On the other hand knowledgeable parents are familiar with the environment and the persons in it and often see it as a "second home." However, actual awareness of the physical environment is often delayed for parents, especially those whose child has been admitted unexpectedly. Their immediate concern and focus is on the child. It may be hours or days before they are aware of the details of their surroundings.

Whether the hospital environment is strange and scary or familiar and comfortable, it is above all a place of hope for parents. The child is brought to the hospital to be helped and hopefully cured. It is this need of help for the child that prompts the parents to view the hospital in an overall positive way. The parent as a non-professional does not have the necessary skill or knowledge to deal with the illness and turns to the health professionals in the hospital setting for help.

Part of the defining of the environemnt has to do with the awareness of physical territorial boundaries and the parent's definition of their ability to move about spatially within the environment. Most often parents are seen at the child's bedside. They come to see this space as belonging to the child and therefore to them and hesitate to venture anywhere else on the unit. With time they may expand their definition of where they can go and their

use of space. The use of space is symbolically significant in terms of parent's feelings of being accepted in the setting. Loose territorial boundaries between the professional and the non-professional foster parental access to such areas as the kitchen, the linen and supply rooms, the treatment rooms. They are in turn more inclined to define themselves as having an accepted place in the setting.

Territorial boundaries between the non-professional and the health professional also exist regarding control over the child's medical treatment and care, and accessibility to information about the child. Where there is strict boundary maintenance by the professional, the staff attempts to exercise their power to control events and limit information to the parents. The parents are then forced to either accept this exclusion orientation and define their positon as one of outsider to the system or enter into negotiation with the staff in an attempt gain inclusion.

Each incident of ambiguity heightens the level of stress of the parents and is therefore incremental in effect. As the various areas of concern are defined and given meaning by the parents, uncertainties are clarified and stress is decreased. Parental definition of the situation then serves to guide their consequent response and behavior.

Factors Facilitating Definition

Parents utilize information exchange and observation in order to define the situation. What parents are told or not told, what

they see and hear provides the input that in turn is interpreted by them to give meaning to the situation and guide their behavior. Information, whether gained through verbal exchange or observation, continually adds to the definition parents have of what is occurring. An influx of on-going facts from the staff to parents can serve to either change or verify the meaning parents attribute to events.

Just as "one cannot not communicate" (Watzlawick et al, 1967), so too one cannot not define for one's self the situation one is in. A lack of information from the staff is symbolically significant to paretns in their definition of the situation. They interpret a lack of information exchange from the staff as an indication that they are being "excluded" from the healing process, "left on the outside" of what is happening, and that the staff has taken over, thus leaving the parent uncertain of his role in the setting.

On the other hand, open communication and free information exchange between parents and staff regarding the child's condition, the role of staff and parents in the healing process, the way the work is structured, and the pediatric unit itself, allows the parent to feel involved and to share in the healing process of the child. On-going information exchange between the health professionals and the non-professionals allows the parent to more quickly define for themselves what is going on and what their expected role in the whole process is.

The health professionals in the setting are in a position to facilitate the parent's definition of the situation. They have the knowledge and information parents need to quickly and accurately give meaning to what is occurring. Whether or not the staff is willing to facilitate this defining process depends on their orientation towards parents.

The first clue to parents regarding the orientation of the staff comes on admission in the form of the staff's greeting to the parent and child, the type of admission procedure, and the process of information exchange. In the situation where the admission is patient focused and the orientation of the staff is one of parental exclusion, parents are given minimal information. This results in the parent feeling excluded, unimportant and in the role of outsider. They experience a lack of control over events concerning their child and their feelings of protectiveness regarding the child are increased. Considerable information may be sought from the parents regarding the child and his symptoms but minimal information given to them about the child's condition and what is going to be done. Explanations from the staff are brief and given mainly to obtain the parent's consent for treatment. In this situation parents may accept their assigned role as outsider, remaining on the periphery and doing nothing to interfere with the work of the staff. Or they may define their role as a more active and inclusive one and move to negotiate with the staff.

An admission procedure that is patient and family focused, in which parents are immediately included in the information network makes them feel involved, acknowledged as a person and as a parent, and gives them a sense of control over what is occurring. The increased informational input enables them to define the situation more quickly and results in a sense of trust and confidence in the staff. Also the more information exchange takes place with the staff, the more likely it is that the parents and staff's definition of the situation will coincide.

The mobility and approachability of the staff can either facilitate or hinder information exchange. If the staff is busy and highly mobile, parents may view them as less approachable and hesitate to interact with them. This lessens the possibility of information exchange and decreases the amount ofinput parents receive in order to assist them in defining the situation.

Not all information that parents utilize in defining the situation comes from verbal communication. Parents also observe the staff, especially in relation to the care given to their child. Parents want and expect the staff to "care" about the child. If the staff provides humanistic caring to the child, the parent begins to feel more comfortable with the fact that the child has to be in the hospital. They come to see the staff as persons to whom they can entrust their child. In turn because they define the staff as trustworthy and caring persons, their sense of protectiveness of the child decreases to some extent. They feel the staff knows

their individual child and will do what is best for him in a technically competent and humanistic way.

The time of the child's admission can be and often is used by the staff to begin their attempts to socialize the parents into their expected role behavior in the setting. Information from the staff provides input to the parents for self-interpretation. The amount and content of the information disclosed is within the control of the staff. The staff therefore does to some extent control what information the parent has with which to define the situation and their role in it. Further because the parent's definition serves to guide their consequent behavior, the staff influences parental behavior to the extent that they withhold or provide information. The overall unit orientation and that of the individual health professional influences whether their efforts to socialize the parent will result in parental inclusion or parental exclusion. The greater the degree of consensus between the parent and staff definition of the parental role, the greater the degree of parental socialization in the setting.

Parents can either comply with the staff's attempts to socialize them into a role in the setting and accept the role assigned them by the staff, or they can attemtp through negotiation with the staff to acquire a role as they have defined it. The naive parent enters the hospital not knowing what is expected of him and is more prone to initially accept the staff's definition of his parental role and behave accordingly. The knowledgeable

parent, who is familiar with the hospital and the staff, has previous experience to assist him in defining his role and a more extensive repretoire of behavior from which to draw. He is also likely to be more aggressive and sophisticated in this ability to negotiate when conflicting definitions of his role exist between him and the staff.

Strategies Used To Aid In Defining

In order to gain information to assist in their definition of the situation, parents utilize strategies which are termed presencing, channeling, tracking and testing.

Presencing refers to the actual physical presence of the parent in the setting. Being present in the setting allows the parent the opportunity to see what goes on with their child, to observe the staff in action and to ask questions, all of which provides input to their definition of the situation. Being on the unit allows the parents to get to know the staff and to begin to feel comfortable in asking them questions. Presencing allows the parent exposure to the structure of the work and expands their definition of how the medical and ward work on the unit is accomplished.

Presencing also forces an awareness on the parents in terms of the acuity of their child's illness. They compare their child's condition with that of others in the setting and either define it as better or worse in comparison.

Presencing can be general, that is, the parent is simply on the unit with the child, or it can be specific for a time or place. Parents use specific presencing in their attempts to gain information regarding particular events such as treatments and diagnostic procedure performed on the child. Their presence during these events increases their level of knowledge and allows them to see not only what is being done but how it is being done.

Presencing is not only helpful to parents in defining what is going on, but is also a strategy used to define their role. Parents observe the work of the staff, which in turn helps them to determine their role based on their definition of the child's need. Parents are concerned that "others won't care for him like I would." Their presence in the setting helps them to determine how the staff relate to the child and how the child's needs are being met. The greater the perceived humanistic caring by the staff, the greater is the parental trust and confidence in the staff's ability to help in meeting the child's needs.

Presencing is not only a strategy used to define the situation but also a consequence of definition. Parents are present <u>because</u> they define the child as "needing me to be here." They see their own role and responsibility as a parent as one of being with the child and maintaining the parent-child relationship. Their presencing is therefore a consequence of their definition of the situation and their child's needs.

Channeling refers to the parent's use of persons in the setting in order to gain information and their attempts to initiate inclusion into the information network. This strategy involves the identification and determination by the parents of those persons in the setting who can provide information, and the directing of their questions to those persons they consider to be appropriate sources of information.

Information from the health professional is necessary if parents are to quickly and accurately define the situation. Parents either channel their way up the formal established hierarchy, such as nurse to intern to resident to private or attending physician; or they single out certain individuals in the setting who have proved to be a willing and creditable source of information. In their attempts to establish the credibility of information sources, parents were frequently observed to ask the same question of many persons. They then compared notes, so to speak, and determined which of the staff provided the most complete and accurate information.

The perceived approachability of the health professional influences the channeling strategy of the parents. Parents frequently defined the nurses as more approachable and therefore either channeled their questions to the nurse, or used the nurse to act as a go-between to ask the physician questions for them.

The naive parents whose level of knowledge and experience is not as great as the knowledgeable parents regarding events occurring in the setting are more limited in their ability to determine to whom they should channel their questions. This doubles their uncertainty. Not only are they uncertain about what is going on, but they are also uncertain about how to find out. These parents limit their channeling and direct their questions to one staff person whom they have come to know; or in an attempt to determine creditable sources they ask the same questions of everyone with whom they come into contact.

The response parents receive from staff to the questions they ask aids them in defining the proper channles of information exchange and the appropriate sources of information. If parents are constantly told by nurses to "ask the doctor" the parent soon learns that the doctor is the only person who either has the information they seek or is willing to disclose it. If parents are given satisfactory answers by the nursing personnel they may channel their questions and concerns no further. Also the parent's definition of the nurse's and doctor's role in the setting influences their channeling strategy. If nurses are defined as persons who give care to the child, but are not perceived as having power or information in the situation, parents will channel their questions only to house officers or attending and private physicians.

Tracking refers to the means parents use to establish contact with information sources. Tracking is the strategy by which parents actively initiate information exchange with health professionals. Parents often referred to their need to "track down" persons in the setting. Tracking is a form of specific presencing and involves "being in the right place at the right time." Parents were often seen stationing themselves in the halls or at the child's bedside in a position where they could observe the persons present on the unit and watch for the arrival of specific individuals.

Tracking can also take the form of "going to the desk" to initiate information exchange. Parents often refer to the nursing station in a way that indicates their definition of this area as the focal place to go with their questions. With experience parents become aware of the best time to get information, and use a combination of presencing and tracking to locate and interact with specified individuals.

When the parents define the physician as their main source of information, they are not content to receive information from the nursing staff and often doubt the completeness and the credibility of this information. They "go over the heads" of the nurses and take it upon themseoves to locate and track down "their doctor."

Parents use the strategy of testing to help them to define their role. This parental strategy involves doing something until being told not to. As one mother said, "it's like climbing

the ladder to see how far you get" (Parent Interview #18). Under the conditions where the parental role in the setting is uncertain and ambiguous and the paents desire an active role in caring for the child, they tentatively become involved in ward work such as bathing, feeding or changing their child. Parents thus test the staff to see how far they will be allowed to go in doing things for their child. The testing strategy encompasses their parenting functions as well as inclusion in the ward work or medical work. As long as the parents are <u>not</u> told that they cannot perform some activity, and they define their role as being involved in the care of the child, they will manage their behavior accordingly. This parentally defined role of inclusion may then be accepted by the staff, or the staff may challenge the parents, attempt to limit their inclusion and establish strict territorial boundaries of work and control between the health professionals and the non-professionals.

Some parents define their role in a way that includes participation in the medical or ward work, other parents are content to be with, protect and nuture the child, and leave the physical care and medical work to the staff, feeling that they are more competent and knowledgeable. Although the definition of their role by the parents is an intrapersonal process of "self-indication," information, verbal and non-verbal clues from the staff, and observation in the setting all serve to assist the parents to arrive at the

definition of the situation and their role within it. Parents utilize the strategies of presencing, channeling, tracking and testing to gain information. This information provides input that allows them to define the situation, to present to themselves the situation which is the basis for their consequent action and behavior.

Consequences of Defining

W.I. Thomas said, "If men define the situation as real then it is real in its consequences" (1967, p. 315). Without diverting into a lengthy discourse regarding reality and what is in fact real, suffice it to say that for this study the parent's perception, the meaning they gave to the situation was of central concern. It is their definition of the situation that guides their behavior in the setting. This is not to say that different individuals in the same situation ca-not have different definitions of what is occurring.

Some definitions held regarding what is goin on in the hospital setting may actually be in opposition to each other and at variance. The staff defines the hospital as a place of work. Their role and identity in the setting is clear. For the parents, hospitalization of the child is a stressful situation often filled with uncertainty. The parents perception of their role in the setting may be unclear and tenuous, so that the same hospital setting may be at once

comfortable for the staff and uncomfortable for parents. Also a condition or situation that may be minor and insignificant to the staff may be of major concern for the parent. This results in differing and sometimes conflicting definitions of the situation. For example, the naive parent bringing a child in for what is medically considered minor surgery may themselves define the situation as major and a crisis. On the other hand a child may be critically ill and the parent may view the situation as less than critical. In these instances of differing definitions each party attempts to relay his definition and meanings of the situation to the other.

Parents may seek to be present with the child constantly relaying their fears and concerns. Their definition of the child's condition may be either verified or invalidated by the staff. The parent may then persist in their original definition or may alter their definition based on input from the staff. The staff can facilitate the parent's definition of the situation by providing them with information about the child, about the staff, the expected role of parents in the setting and the way in which the work is structured. This is an attempt on the part of the staff to relay their definition of the situation, which the parent is then free to accept or refute.

In order to facilitate their work, the health professional attempts to influence the non-professional in the setting to behave

in a manner that is consistent with their orientation and expectations of them. If the staff views the parent as a visitor and outside of the medical or ward structure of work and the parent accepts this definition of self in the setting, a blending of definitions and parental socialization in the setting results. The same is true if the staff views the parent's role as an active one in which the parent participates in the ward and/or medical work involving the care of the child and the parent concurs with this definition and behave accordingly. Because of the recognized power position of the staff, the fear of punishment and the parent's motivational investment in the goal of health for the child, they may choose to define the situation and their role to coincide with the definition of the staff, not wishing to antagonize or upset them and in turn jeopardize the care of the child.

Parents can and do however resist the socialization attempts on the part of the staff. This resistance results in conflict concerning the definition of the parent's role in the setting and their consequent behavior. Each person acts according to his definition of the situation and therefore behavior resulting from conflicting definitions is at variance and contradictory. When conflicting definitions of the parent's role exist the parnts can either re-define their role, accepting the staff's definition, or they can move to negotiate in an attempt to alter the staff's definition of their role.

The way in which a situation is defined determines the basis on which one establishes behavioral priorities. Because the staff members define the hospital setting as a place of work, their priorities are based on the work needing to be accomplished, taking into consideration all the patients on the unit. The priority for the parent is the health and well-being of their own child, and more so depending on the severity of the child's illness. Parents may therefore seek staff to do things for their child at a time when the staff's priorities are elsewhere or with another child. Depending on the experience of the parent, the length of time spent in the setting, their knowledge of the staff and the overall work to be done, the parent may br able to re-define their child's and their own needs and priorities, especially if they are not of an emergency nature, to coincide with the priorities of the staff. The parent's perspective and definition of the situation is then broadened to include other patients on the unit and the work of the staff.

Differing definitions and differing priorities between parents and staff can lead to conflict and negotiation in an attempt to exert power and control. The way in which a situation is defined gives meaning to the reality. The behavior of the defining individual is then the resulting consequence of the meaning that individual attributes to the situation.

Re-defining

The definition of the situation is an on-going process that occurs throughout the hospitaliziation. Any situation that results in change is a source for re-defining. Day to day events may serve to alter the parent's definition of the situation and bring about a re-entry into the phase of parent-setting stress. Such events include the acuity of the child's illness, the varioius staff members the parents encounter, the level of trust parents have in the staff, and the time parents spend in the setting.

A change in the acuity of the child's illness may alter the parent's definition of their role. For instance when a child is acutely ill, on monitoring machines, with tubings inserted, or when a child just returns from surgery, parents may be hesitant to do anything for the child or even touch him fearing they will hurt the child. They are unfamiliar with the equipment and are content to leave the majority of the care to the staff. As the child's condition improves the parent is more willing and feels better able in terms of skill and knowledge to share in the work of caring for the child.

The amount of time the parents spend in the se-ting may serve to alter their definition of the situation. Staff persons who were initially viewed as intimidating become known to parents as individuals. This "coming to know" process alters the parent's definition and orientation towards them. Parental presencing in

the setting allows for observation of the staff. As parents come to know how the staff cares for their child, their trust in the staff may increase and alter their definition of their own role and functions. On the other hand, events can occur that decrease the parent's trust in the staff and increase their sense of protectiveness of the child and their need to increase the time they are present in the setting.

An increase in information exchange can alter their definition of the situation and be a cause of re-definition. A child who is initially hospitalized for what was believed to be a curable condition may be subsequently diagnosed as having a chronic or life-threatening disease. This change in diagnosis is a cause for re-definition.

Re-defining is on-going and can be affected not only by external input but also by internal states of the parents. The physical and emotional state of the parent influences their definition of the situation. If the parent is rested and the child's condition is imporving, the parent is more inclined to view events in a positive way. If the child's conditon becomes worse, the uncertainty of the outcome is increased, thereby increasing the stress for the parent. In this latter situation the parent tends to become more anxious, more critical, and to define the situation as unsatisfactory.

Summary

The initial phase parents go through in the hospital setting is that of parent-setting stress. This is a time of uncertainty. In order to handle the stress and situationally manage their role, parents utilize the implementing process of defining. Defining, giving meaning to the situation, is an intrapersonal process that guides their subsequent action and behavior.

Information from and observation of the staff provides input that facilitates the parent's definition of the situation. The health professional can attempt to impose his definition of the situation on the non-professional thereby influencing consequent behavior. The non-professional is however free to accept or reject the staff's definition. Conflict occurs when definitions of the same situation are not congruent.

With the defining process parents move into either a state of adjustment, that is parent-setting fit, or into a state of opposition with the system, or parent-setting conflict. The factor which determines the phase the parents move into is the degree of consensus that exists between the parents definition of the situation and the staff's definition of the situation.

There is no specific time span that can be placed on this phase of parent-setting stress. Stress results from uncertainty and ambiguity, therefore changes in the situation at any time may be a cause for re-entry into this phase. The length of time a parent

remains in this phase is influenced by their ability to define for themselves what is happening and what their role is, and the willingness of the staff to provide information that will facilitate the process of defining.

Section II

Phase of Parent-Setting Conflict: Balancing/Negotiating

Following the defining of the situation, parents may then move into the phase of parent-setting conflict. This phase is one in which parents view themselves, for one reason or another, as being in opposition to the hospital system. There is disagreement and opposing desires or needs between the non-professiona and the health professionals in the setting. Unlike the phase of parent-setting stress in which the stress results from uncertainty and is non-specific, conflict is the result of specific opposing views and/or needs.

The implementing processes of situational role menagement in this phase are those of balancing and negotiating. The two processes are closely aligned and both can be viewed as a means of "coming to terms." Balancing is coming to terms with self. This is an internal process, prior to action, in which the risks of an action are weighed against the benefits to be accrued from the action. Negotiating is coming to terms with others and is an interactional process engaged in for the purpose of control over events and one's part in them. Both processes are an attempt on the part of the parents to manage their role within the situation in a manner that best meets their needs and the needs of the child.

Balancing

Balancing is the process that occurs prior to action and/or negotiation with others. Parents define the needs of their child and their own needs and determine how best those needs can be met. When a child is hospitalized the parents must balance their role as parent-of-the-hospitalized child against their other role commitments such as employee, husband or wife, parent of other children. The benefits that would accrue to the child having the parent present in the hospital are weighed against the risks involved in the parent not being with other family members or in taking time off from a job. For example, several mothers balanced in favor of the hospitalized child and chose to remain with the child throughout the hospitalization. They saw the hospitalized child's needs and the benefit to him as greater than the risks involved in absenting themselves from their family at home.

Other parents balance in a way that requires a re-setting of priorities which include both time spent at the hospital and the maintenance of a life style that is as normal as possible. The acuity of the child's illness has an influence on the balancing process. The sicker the child, the more inclined parents are to balance in favor of being with the hospitalized child. The child's need to be nurtured by the parent is heightened as well as the parent's need to protect the child and to maintain the parent-child relationship.

Parents also balance their feelings of responsibility as parents against their own dislike and uncomfortableness at seeing the child sick and in pain. They are often unwilling to risk a decrease in self-esteem that would result from their shirking what they consider to be a parental responsibility to provide comfort and support to their child by their presence. As a result parents oftentimes balance to be with their child despite the inclination to avoid situations in which their child is in pain.

Parents balance in the area of control over the child. Parents are willing to risk ceding over some control of the child and what happends to him for the benefit of receiving medical help and attaining the goal of health and well-being for the child. However, parents are less willing to relinquish their parental function of protection. Their child's need to be protected from unnecessary trauma often outweighs the perceived risks involved in speaking out. Several parents related incidents in which they either questioned the necessity of what was being done or attempted to interfere with the treatment given to their child because they defined the situation as being unnecessarily traumatic for the child.

The risks as perceived by parents involved in speaking out and interfering with the staff are those of decreased care or concern of the staff for the child, or repercussions for themselves from the staff, such as being ignored, excluded from information or restricted from access to the child. The benefits perceived by

parents from interfering are better care for the child and a more adequate meeting of his needs.

The scale or risks versus benefits is tipped when parental tolerance levels are reached. Tolerance levels are individual and different events can occur which serve to push the tolerance level of parents past its limit. Parents will go along with what is happening to their child until such time as they feel the child's needs, either physical or emotional are not being met. Parents relate such things as, "obvious lack of care," "neglect," or "mistreatment" of the child as events that would tip the scales and provide a cause for their interference. On the whole parents hesitate to interfere with the work of the staff. The perceived power position of the staff acts as a deterring factor to parents. Not only do parents fear repercussions for the child and temselves if they interfere but they also acknowledge the legitimate and expert power of the health professional and their knowledge and ability to be of help to the child in areas where the parent as a non-professional lacks the knowledge or skill.

Another area of balancing revolves around the care given to the child. Although the child has medical needs in light of his illness, parents are also concerned that his psychological and emotional needs are met. Because parents are placing their child in the care of the staff, they are concerned that all his needs are met. They may feel that only they can meet the nurturing

needs of the child adequately and therefore balance their lives in a way that allows them to be present with the child throughout the hospitalization. After an initial period of observing and getting to know the staff, parents can re-balance in a way that may allow them to share this nurturing function with the staff. Their trust in the staff may be such that they have seen and know that the staff give humanistic care to the child and that his nurturing needs can be to some extent met by the staff. In other words, there is no longer a perceived opposition in relation to meeting the child's needs.

Just as defining the situation is an intrapersonal interpretive process that guides subsequent behavior, so too balancing is an internal process involving the weighing of risks and benefits in order to determine subsequent behavior. Balancing involves coming to terms with self in light of opposing needs or desires. It is a means of resolving opposition in order to manage one's role in a situation.

Negotiating

Negotiating is the interactional process of coming to terms with others for the purpose of control over events and one's part in them. Negotiation is a means used to resolve opposing views or definitions of the situation. According to Nierenberg (1968) "every desire that demands satisfaction - and every need to be

met - is at least potentially an occasion for people to initiate the negotiating process." (p. 8)

Parents as non-professionals in the hospital setting with their sick child are in a position of responsibility with little or no authority. They have limited power in the system compared to the legitimate and expert power of the staff. The feelings of powerlessness that parents experience can undermine their self-identity and their identity as parents. Parents frequently relate, "if only I could do something to help." It is this need to help, to contribute, to have some place in the healing process of the child and to have some control over what is happening to the child that prompts their negotiating. Being able to perform their parenting functions, being involved in the ward work or medical work, being included in the information network all contribute to their sense of inclusion and control. When these parental needs of inclusion and control are thwarted, conflict results.

Staff orientation towards parents may be such that their expectations of the parents place in the division of labor differs from the parent's definition of their role resulting in opposing views. Once having defined themselves as being in opposition to the health professionals in the setting, and having weighed the risks and benefits involved in action, parents may choose to negotiate.

Negotiating is ordinarily an informal process engaged in when specific situations or conditions arise. The major focus of negotiation revolves around the role of the non-porfessional in the setting vis-a-vis that of the health professional. Included in the area of negotiation is the amount of parental access to the child, the degree of inclusion in the work of caring for the child, and inclusion in the information network. When negotiating parents in this study were found to utilize the strategies termed presencing, friending, inching, legitimizing, contracting and threatening.

Presencing

In the previous section, presencing was described as a parental strategy used to retrieve information in order to define the situation. Presencing is also a negotiating strategy. Parents are present in order to nurture their child, to protect him from unnecessary trauma and to maintain their relationship with the child. Their very presence affords parents the opportunity to perform these parenting functions despite what may be opposition from the staff. Presencing also forces an interaction with the staff and provides the opportunity for negotiation. Although parents who are present can be ignored by the staff, the likelihood of interaction taking place is greater than when they are absent from the setting.

Presencing allows parents the opportunity to gain information and facts which they can then use in further negotiating their role in the care of their child. Parents who see that "the nurses are busy" may then move in to assume some of the ward work such as bathing, feeding or changing the child as part of their role.

Parental presencing also serves as a control on staff behavior, increasing the accountability of the staff to the parent. In order to prove to the parents that they do possess the knowledge and skill required to care for their child and that they are doing their job, staff often, as Goffman (1959) puts it, "dramatize" and "make visible" their work. When the parents are present, the staff and their work are "on show."

Staff with an exclusion orientation who maintain strict boundaries between the professional and the non-professional are more intimidated by parental presence and attempt to foster in parents the impression that their work is not only important, but that it is unique and specific to the professional. Staff with an inclusion orientation are less intimidated by parental presence because they are less concerned with boundary maintenance and willing to allow parents to share in the work of caring for the child. Parents presence themselves in order to make certain the needs of the child as they perceive them are being met. If the care given by the staff is viewed as less than adequate by the parents, they take advantage of their presence and attempt to negotiate.

Friending

Friending is the strategy by which parents get to know the staff and become friends with them, thereby changing the relationship from a professional to a social one. It is an attempt to equalize the power base and to eliminate "one-upmanship." As friendship is built up, so too is the obligation on the part of the other, which in turn cuts down on the power one person has over the other. In a friend relationship the issue of power is minimized, and control over events and one's role in them becomes a collaborative venture.

Using the friendship strategy parents can more easily "take the role of the other," that is, they come to understand and appreciate the work the staff has to accomplish. In turn they relay this understanding to the staff in their comments to them. Staff most often respond favorably to the friending strategy feeling that parents appreciate them as individuals and they in turn relate to the parents on a more social and less formal basis.

Friending fosters mutual trust between parents and staff. As a consequence when parents feel that staff are their friends, they approach them on that basis to negotiate. Negotiations regarding what parents want to do for their child and what they are allowed to do by the staff are then carried out in an atmosphere that is more social than professional and therefore non-threatening to either parent or staff.

Friending also allows parents a base from which to negotiate for more information regarding their child. Parents view being kept informed as one of their most important needs. When information is lacking they may seek out certain staff they consider to be friends to negotiate for information. Parents frequently relate that it is "easier to ask questions once you get to know the staff." Friending is an attempt on the part of parents to alter their relationship with the health professional and set the stage for negotiations that are likely to result in satisfaction for them and for the staff.

Inching

Another strategy used by parents is that of inching, whereby the parent's role is negotiated a piece at a time. The parent moves from a position of exclusion to one of inclusion into the domain of the health professional. For example, a parent first asks to be allowed to give the child his bath, then to feed him. Then he may ask to give the child's oral medications and further to be allowed to stay with the child during procedures or to learn to do the medical treatments required.

This strategy serves to increasingly legitimize the parent's presence and role and foster the staff's trust of the parent. As parents begin to learn the ropes, they know to whom they can go with their requests and with whom they are most likely to negotiate

satisfactorily. Once they have successfully negotiated a piece of their role, they can use this example to negotiate further. For instance, parents were observed to say to staff, "well that other nurse let me wash him," or "I've been giving his medications, it seems to work best that way."

Parents also use inching to gain information. They find one staff member with whom they feel comfortable, and go to that person for information and explanations regarding what is happening. They begin to learn medical terminology and are then armed with information and the language they need to negotiate further with others in the setting.

As the non-professionals proceeds to "inch" his way into inclusion within the territory of the professional, the professional must reciprocate and yield part of that territory. There is therefore inching-in on the part of the non-professional and yielding-over on the part of the professional.

Legitimizing

Another strategy used by parents in negotiating is that of legitimizing. Legitimizing involves the assertion by the parent of his identity and position as a parent and therefore his right to information and inclusion in care. It is an attempt to assert their legitimate authority albeit situationally limited over the child and to equalize the balance of power and assume some control in the setting.

Parents often assume their right as parents to be kept informed regarding their child. They negotiate their inclusion into the information network based on that right and demand information from the staff.

Parents also feel that they can particiapte in the ward work because these activities such as bathing, changing or feeding the child are within their scope of knowledge and skill as parents. This need to be involved in giving care to the child is based not only on their ability and desire to do so, but also on their belief that it will be better for the child.

Legitimizing is also based on the parents experiential knowledge and previous experience with what is going on. Legitimizing based on prior experience is most often used by parents to gain access to procedures performed on their child. The single most effective means of gaining entry to these procedures is the parent's assertion, "I've seen it done before and I can handle it." Parents negotiate inclusion into procedures in order to provide support to their child, to gain information, and in the hopes that their presence will facilitate the medical work to be done. It is obvious that the knowledgeable parent has an advantage in this instance over the naive parent. Not only are they more aware of the need to legitimate and assert themselves, but they also have the actual prior experience upon which to base this legitimation. They have a history not only with the child, his

illness and treatment, but also with the hospital system and the persons in the setting.

Contracting

Contracting is another strategy used by parents to negotiate their role. This is the most formalized of the parental negotiating strategies and involves a verbal consensus between parents and staff regarding the role of each in caring for the child. Contracting may occur on admission or on a day to day basis with the staff. The parent may declare their intention to be with the child and do as much for the child as possible. On the other hand the parent may be content to have the staff do all the physical care for the child, leaving them free to perform the parenting functions.

Contracts may be negotiated initially or at a later time during the hospitalization after the parents have had a chance to define the situation for themselves. Contracts can also be changed or re-negotiated at any time based on the child's needs and condition. Parents of acutely ill children may choose to remain constantly with the child at first and when the child is recovering re-negotiate the time they spend with the child and their place in the division of labor. Parents who work or have other children at home may contract with the staff to delay specific care for the child such as a bath or a treatment until such time in the day when they can be present to give this care.

Threatening

Both parents and staff can also use the strategy of threatening in a resort to using the "ace in the hole." Staff threaten to exclude the parent and limit their accessibility to the child and their opportunity to perform their parenting functions. For example, parents wishing to remain with their child may be persuaded to leave, with the staff either evoking hospital and unit policies or saying that teh parents absence would be best for the child. This latter staff strategy devalues the parent and his role in the healing process, and makes the parent, already uncertain of his role feel less secure in his behavior. Parents can threaten to complain to higher authority about the care given to their child, to "make waves" so to speak, or they can threaten to remove the child from the hospital and the staff's care.

The threats for the most part are symbolic and represent potential and not actualized behavior. However, the effect of making one another aware of the existence of this potential often serves to facilitate negotiations. Threatening is used most often by the staff as a counter-strategy to inhibit parental inclusion and control parental behavior. Parents also use threatening as a means of controlling staff behavior. The actualization of a threat by parents is used only as a last resort to conflict resolution.

Staff Counter-Strategies

Parents in the hospital setting develop strategies in order to negotiate with the persons in the setting. The staff also use strategies and counter-strategies in negotiating. One such counter-strategy is information control. The staff is the source of parents information, and to a large extent controls the amount of information a parent receives. They can limit the information given to parents either because they themselves do not have the information, or because they choose not to disclose it. In order to decrease the amount of parent-staff interaction and control situations in which parents may seek information, the staff can increase their mobility, limit their accessibility and visibility to parents, or present themselves to parents in a manner that relays un-approachability. All of these techniques on the part of staff comprise the strategy of information control. Parents can thus be intimidated by the staff and although they see the need to negotiate they may not feel comfortable in doing so.

The staff also uses the strategy of legitimizing, based on their positions of power and authority in the setting. The source of that legitimation is their professional status which is sanctioned by the health profession and the hospital system. They also have the advantage of numbers, in that there are many staff in comparison to the individual parent. One source of staff legitimation is hospital and unit rules and policies. Staff often resort to these

rules and policies in an attempt to control parental behavior.

The staff frequently used their power position in an attempt to control parental behavior and evoke parental conformity to what they deem to be best, either for the child or for the efficient functioning of the unit and organization of work. A staff tactic of legitimizing is that of saying to the parent, "I think it would be best if...." This places the parent as a non-professional in the awkward position of having to challenge or refute the health professional. Because they perceive the risks involved in challenging or ignoring the health professional to be high, parents will most often conform to the suggested behavior.

Summary

Balancing and negotiating are the implementing processes parents use to manage their roles in the phase of parent-setting conflict. Conflict occurs when there is disagreement or opposition between the parent's definition of the situation and that of the staff.

There is no guarantee for the parent that negotiating will result in satisfaction for them or resolution of the perceived opposition. In negotiations between the professional and the non-professional, the professional has the advantage of having established power in the setting and of being on his own turf, so to speak. Parents, as non-professionals in the setting, are most

successful in negotiating their inclusion when they use a combination of presencing, inching and friending. Presencing and inching help to alter the staff orientation towards them and facilitate inclusion, and friending alters the power base of relationships and facilitates non-threatening negotiation.

When negotiations are successful and opposition is resolved, parents move into the phase of parent-setting fit in which there is an agreement between parents and staff regarding the definition of the situation and the parent's role in that situation. If negotiations with the staff are unsuccessful for parents they either remain in the phase of parent-setting conflict, attempting frequently to re-open negotiations, or they re-define the situation, balance risks and benefits of further negotiation and move into the phase of parent-setting fit. The possibility of negotiation between the professionals and the non-professionals in the setting is, at least theoretically, always open. At any time during the hospitalization events can occur which call for a re-definition of the situation. Parents then re-enter the phase of parent-setting stress, which in turn may lead either to further negotiating or to fit.

Section III

Phase of Parent-Setting Fit: Settling

The phase of parent-setting fit can be entered into either immediately following the definition of the situation by parents in the phase of parent-setting stress, or can result from balancing, negotiating and the resolution of parent-setting conflict. Fit occurs when there is consensus between the health professional and the non-professional regarding their respective roles in the setting.

When the orientation of the staff is one of exclusion, the parents are perceived as outsiders to the structure of work, the information network and the power structure. Strict territorial boundaries are maintained to separate the professional and the non-professional. If the parents accept this definition of the situation and their role and in so doing remain on the periphery as outsiders, a parent-setting fit results.

In the situation where staff have a parental inclusion orientation, parents are accepted and expected to become involved in the structure of work. They are given a place in the division of labor, included in the information network, and power and control is shared with the staff. When the parents, accepting this definition, manage their roles accordingly, parent-setting fit occurs.

Settling

The implementing process of this phase is that of settling. Settling involves role accommodation and is an interactive process whereby the respective roles of the parnt and staff are located and interrelated in a way that is relatively satisfying, under the circumstances, to parents and to staff. In relation to the hospital system parents either settle-out or settle-in.

Settling-out is the process of role management whereby the parents, in consensus with the staff, define their role as one outside of the health care system. Although the child, as the patient is incorporated into the system, the parents remain on the periphery. They are emotionally invested and concerned about the health of the child, but their activity is limited to the familial functions of providing comfort and support to the child and maintaining the parent-child relationship. Their role is, on the whole, passive and one of non-interference. They visit the child but assume no place in the medical or ward work of caring for the child. Activities they would ordinarily perform in the home are no longer seen as being within the scope of their role performance or responsibility within the hospital setting. They not only assume and expect the staff to perform these functions, but view it as beneficial to the child if they do.

Parents who have settled-out accept and respect the territorial boundaries separating the professional and non-professional and

make no attempt to cross them. They cede their control over events to the staff and accept the treatment regime that is planned. Their movements in the setting are limited to the child's bedside and they do not attempt to trespass into staff territory. They seldom force interaction with the staff but wait for the staff to initiate interaction and information exchange. They often relate to all the staff as a body, that is, they do not know the staff by name or as individuals, only as "doctors and nurses." To them the staff are "all the same" and all there to help the child. Their trust in the staff is based on legitimate and expert power they perceive the staff to possess.

Parents who manage their roles in the setting in a way that results in settling-out are quick to accept the staff's definition of the situation in order to avoid conflict and disagreement. They are unwilling or unable to risk negotiating either because of their fear of reprisal, or because of their lack of experience with health professionals and the hospital setting.

No phase of situational role management is fixed. Therefore parents who have at one point settled-out may gain experience and information that increases their knowledge level. This alteration in knowledge and experience can result in a change in their definition of the situation which can in turn lead to conflict with the staff. They may then elect to negotiate. Through negotiating they may succeed in reaching a consensus with the staff that allows them a

more inclusive role and thus move into parent-setting fit and settling-in. If the staff however, is unwilling to allow any parental inclusion, the parent either remains in conflict or goes through a process of re-defining that again results in parent-setting fit and settling-out. Staff with an exclusion orientation attempt to socialize parents into a fit, but only one of settling-out.

Settling-in involves a parental process of role management in which the parent and the staff define the parental role as one of inclusion and involvement in the healing process of the child. Both the patient and the family are incorporated into the system. Parents settle-in either because the definition of their role as inclusive and participatory initially coincides with that of the staff, or they go through the phase of parent-setting conflict using balancing and negotiating to make a place for themselves in the system. Staff with an inclusion orientation ofster parental settling-in and direct their socialization attempts to obtain that result. It is when the staff are of a middle of the road orientation that parents may have to utilize the implementing process of negotiating in order to settle-in. Staff with an exclusion orientation inhibit settling-in, using counter-strategies to decrease negotiating. It is in this latter situation that parents have the most difficulty in attempting to manage their role to achieve settling-in, if in fact they can at all.

When parents settle-in they are included in the information network in the setting. They are not hesitant to take steps to retrieve information or to initiate interaction with the staff. The staff also seek them out and keep them informed. The territorial boundaries between the professional and the non-professional are easily crossed, allowing the parent not only a share in the division of labor, but a share in the control of events regarding the child. There is a mutual trust between the parent and staff. Parents know the staff as individuals and often consider them to be friends.

These parents manage their roles in a way that allows them to feel they are contributing along with the staff to the child's improvement. Within the implementing process of settling-in, parents can either choose to perform only their parenting functions of nurturing, protecting and maintaining the parent-child relationship, or they can elect to become involved in the ward work or medical work. When the parent settles in, there is a recognized and accepted place for them in the division of labor. They perform their parenting functions without restriction by the staff, at times and in places within the setting they feel to be appropriate.

The knowledgeable parent who has had experience with hospitalization of the child and with the child's illness most often manages his role in a way that results in settling in. They are not only more willing to risk negotiating but are often more sophisticated in their ability to negotiate and possess a larger repertoire of strategies with which to negotiate.

Even though parents have settled-in events may occur throughout the hospitalization that cause them to re-enter the phase of parent-setting stress and re-define the situation, or they may move into the phase of parent-setting conflict and re-negotiate their role. However, once parents have managed their roles in a way that results in parent-setting fit and settling-in, it is more likely that re-entry into other phases will be brief, and that negotiation will take place using the friending strategy resolving oppostion in a way that allows for future settling-in.

Summary

In the phase of parent-setting fit, whether parents have settled in or settled out, there is an understanding between parents and staff regarding their respective roles in relation to the child. Each knows what the other will do for the child and each has located the other, so to speak, in terms of their role performance. It is a phase of relative calm within which the needs of the child, the parents, and the staff are being met in a way that each considers relatively satisfying in the situation.

The phase of parent-setting fit is the most productive and efficient in terms of the structure of work. There is a level of behavioral predictability. The division of labor is arranged in a way that both parents and staff know what the other will be doing for the child, whether this means that parents will be involved in the ward and/or medical work or choose to remain outside of

this work. The orientation of parents and staff toward each other is clear and accepted by both. The balance of power, who has control in the situation, whether it is the staff or a parent-staff shared control, is agreed upon.

In this phase of parent-setting fit, parents have become "socialized." That is they have learned behavior, either through defining or by balancing and negotiating, which is socially relevant and appropriate in the situation (Brim, 1970). They have managed their roles in a manner that is in accord with their expectations and those of others in the situation.

The stronger the staff orientation and the greater the solidarity among the staff regarding a given parental orientation, the more consistent will be there efforts to socialize the parents accordingly. In this situation it is difficult for an individual parent to resist the situational pressures to conform. Because the child, as the patient, has been temporarily incorporated into the system, the alternatives for parental behavior and role management are limited to conforming, remaining in conflict, or absenting themselves from the setting. Since the child is a member of the family system and the primary function of the system is to maintain itself, parental absence from the setting is not an attractive alternative. Constant conflict and negotiation regarding their role performance is costly in terms of the energy output required, especially at a time when a great deal of energy and concern is focused on the

welfare of the hospitalized child. Therefore parental roles in the setting are most often managed in a way that takes into account the existing situational factors and pressures as well as personal expectations and needs.

Chapter Summary

The process of situational role management was found to be comprised of three aspects: situational factors, conditions that affect and are affected by role management; implementing process, means employed to manage roles; and phases, stages of role management. Each of the phases of situational role management is indicative of the current relationship between the non-professional and the health professional.

In the phase of parent-setting stress, ambiguity and uncertainty exists and defining or giving meaning to the situation is the implementing process used by parents to reduce the uncertainty and decrease the stress. Opposition and disagreement between the parent and the health professional characterize the phase of parent-setting conflict. In their attempts to resolve the opposition, parents either balance or negotiate. The phase of parent-setting fit is characterized by consensus between the parent and the health professional. In this phase, parents employ the implementing process of settling or role accommodation, and have learned appropriate behaviors so that they have become socialized within the setting.

Situational role management is an on-going process of parental role determination that is influenced by changes in the situation. The phases of situational role management are therefore not fixed and parents can enter and/or re-enter any of these phases throughout a given hospitalization. There is also no set time frame surrounding a given phase. However, it was found that once parents manage their roles and have settled-in, their re-entry into the phases of stress or conflict was comparatively brief.

CHAPTER VI

SUMMARY AND IMPLICATIONS

When a family member is hospitalized, there is an interface of the hospital system and the family system. As non-professionals, the family comes into contact and interacts with professionals within the domain and social world of the health professional. The patient is incorporated, albeit temporarily, into the system. The family members however have no formal position or role within the system.

The family is a unit, a system of interdependent and inter-related persons. They are all therefore affected by the illness of a family member. Although the family depends on the health professional for the medical management and treatment of the patient, their relationship with and emotional investment in the patient necessitates some degree of involvement in the hospitalization and illness experience.

In order to continue in their familial relationships, provide support to the hospitalized family member and maintain their family identity, family members attempt to locate their place within the hospital system and determine behavior that is appropriate for them in the setting.

When a parent enters the pediatric setting with his sick child the definition construction and enactment of the parental role results in part from the interactions that take place within that

situation. This behavioral determination on the part of the parent as a family member and a non-professional has been conceptualized and formulated in the proposed theory of Situational Role Management.

The Theory of Situational Role Management

The theory of situational role management is a grounded substantive theory that provides a framework of interrelated concepts and processes relevant to role construction and determination under the condition of an institutionally structured system of positions and role relationships. It is a theory of process and as such addresses the problem of movement of non-professionals toward inclusion into the health care system.

This study has examined situational conditions and ongoing parent-staff interactions in the pediatric in-patient setting. When a young child is hospitalized the parents, despite their child's altered state of health and the transfer of the child from the home to the hospital setting, endeavor to maintain their parental identity and to function in the role of parent. Their behavior in the setting is dependent on their ability to manage their role in the situation.

The process of situational role management is comprised of three aspects: situational factors that exist in the setting which affect parental role management; phases of role management signifying the current relationship between the parents and others in the setting and progress in their movement toward inclusion into the

system; and implementing processes parents utilize in their efforts to manage their role. Certain factors determine the phase of situational role management the parent is in. They also influence the parent's progression through the phases and the implementing processes parents utilize to manage their role.

The performance of a role is situationally dependent. Factors existing in the situation, as well as expectations and response of others within that context must be considered in relation to a given role. The orientation of the hospital, the unit and the staff represents their philosophical perspective towards parents and sets the stage for interaction. According to Strauss et al (1964), institutional conditions influence the practice of the professionals who work in a given setting. Therefore, the overall hospital and unit philosophy will affect the ability of the individual health professional to operationalize their personal philosophy. Orientation can be placed on a continuum from one of parental exclusion to one of parental inclusion. A parental inclusion orientation fosters parent-staff interaction, while a parental exclusion orientation limits and restricts interaction. The place the staff occupies on this exclusion-inclusion continuum determines their willingness to verbally reveal their orientation to parents. The greater the commitment of the staff to an inclusion orientation the more openly they communicate this to parents. The result is more explicit expectations of the parent by the staff, and greater role clarity for the parent.

The hospital is a place of work and the established territory of the health professional. The performance of their work fosters and validates their professional identity. The structure of work--the manner in which activities and tasks are organized--determines how the work is accomplished, by whom, when, and what priorities are set. Work can be structured to include or exclude parental invovlement based on theorientation of the staff and the desire, knowledge and ability of the parent to become involved.

Parents are included in the structure of work in two ways. First, they are allowed a place in the division of labor and a role in caring for their child. This affects the parents' role performance. Second, they are perceived as being within the scope of the work of the staff. This affects the role of the staff and the way they structure their work. Part of their job then becomes working with the parents to help them so that in turn they can help their child, initiating them into their role as parent-in-the-hospital.

The balance of power determines who is in a position of control and able to influence and direct events in the setting. When the staff has high control needs and a parental exclusion orientation, power resides in the staff and strict territorial boundaries between non-professional and professional are maintained, thereby minimizing parental power and control. Staff with an inclusion orientation are willing to share power with the parent and territorial boundaries are easily crossed.

Parental control can be viewed as being either on a performance level or an intellectual level. When parents are allowed to share in the division of labor and assist in caring for the child, the control relates to performance. When the parent is kept informed regarding the treatment of the child and events in the setting, the control is on an intellectual level. Informational input gives the parent a greater understanding of the situation and allows him to make a more informed choice of compliance or interference.

An essential activity within the hospital setting is that of information exchange, the giving and receiving of messages. The information network includes a wide variety of persons and is highly complex. Parental inclusion in the information network is related to staff orientation, time related factors, and the desire and ability of the parent to penetrate this network. The more information parents receive, the more quickly they are able to manage their role and to progress in their movement into the health care system.

The phases of situational role management represent the conceptualization of parental movement and progress toward relative inclusion into the health care system. These phases are fluid rather than fixed or time dependent. Parents move from one phase to another depending on on-going events and interaction in the setting. They can enter and/or re-enter any phase throughout a given hospitalization. Parental behavior is determined in a way that encompasses internal and interactional processes of role

management in view of the existing situational factors in the setting.

The phase of parent-setting stress is characterized by uncertainty on the part of the parents in terms of the child's condition, their role and that of the staff, and the hospital setting. This phase represents their initial state at entry into the system. The degree of uncertainty that exists is altered by the amount of previous experience of the parent with the child's illness and the hospital. The implementing processes of defining/redefining which are internal processes of self-interpretation are used by parents to give meaning to the situation, which in turn guides their behavior. Within the phase of parent-setting stress parents utilize the strategies of presencing, channeling, tracking, and testing to facilitate their definition of the situation and the management of their role.

The phase of parent-setting conflict occurs when there is opposition between the parent and the staff. The primary cause of opposition relates to the definition of the parent's role vis-a-vis that of the staff, and the balance of power. In this phase parents are being hindered in some way by the staff from performing their role as they have defined it, or their control needs are being thwarted.

In this phase, parents utilize the implementing processes of balancing and/or negotiating. Balancing is an internal process, prior to action, of coming to terms with self, and weighing the

risks and benefits that would result from the contemplated action. When the risks of action are considered to be too great, balancing results in re-definition to resolve conflict. When benefits outweigh risks, negotiation results. Negotiating is an interactional process of coming to terms with others.

The strategies of presencing, friending, inching, legitimizing, contracting, and threatening are used by parents to negotiate in an attempt to resolve opposition and gain control in the situation. When the staff seek to maintain control and inhibit negotiations, they use the counter-strategies of information control, legitimizing, and threatening. The outcome of negotiating depends on the strength of the staff orientation and the experience and negotiating strategies of the parent.

The phase of parent-setting fit is characterized by consensus and clarity. Parents and staff are aware of their respective positions and roles and are in agreement regarding them. Fit is achieved either through initial consensus between parents and staff regarding their respective roles, or through negotiation and conflict resolution. Fit occurs when the parents have learned behavior that is appropriate and relevant in the setting and have managed their roles in a way that coincides with this expected behavior. The implementing process of this phase is that of settling, which is an interactional process of role accommodation within the setting. Parent-setting fit does not guarantee inclusion, only consensus and role accommodation, and represents socialization of the parents

in the setting. Parents progress either into inclusion and settle-in; or inclusion is blocked by the staff and the parent accepts a position of exclusion for the sake of fit and settles-out.

The continuum of parental exclusion-inclusion with regard to the health care system does not represent absolutes, but points to directions. Neither complete inclusion or exclusion was found to exist. Total inclusion of the parent would necessitate obliteration of territorial boundaries between the professional and the non-professional and negation of the parental identity. Total exclusion would require complete absence of the parent from the setting, a severing of the parent-child relationship and disruption of the family unit, and a negation of the parent's legitimate responsibility and authority for the child.

Implications for Practice

The aim of research is to increase knowledge and to formulate general principles which explain certain features of natural empirical phenomena. Clinical nursing research has the added dimension of applicability to patient care. It is a search for knowledge that will explain and verify with the ultimate goal of improved patient care. Situational role management as a theoretical formulation has implications for the health professionals in the practice of pediatrics and family health, and provides a framework for addressing the problem of parental behavior in the pediatric in-patient setting.

Understanding what happens to parents when their child is hospitalized from the parent's perspective can provide health professionals with the information they need to assist parents and facilitate their role management. The theory of situational role management, inclusive as it is of the factors that exist in the setting, can assist the staff in recognizing their part and their influence on parental behavior.

Using the theory of situational role management, the aim of the health professional would be to decrease parent-setting stress, minimize parent-setting conflict, and increase parent-setting fit. Put another way, the health professional needs to decrease uncertainty, minimize opposition and increase consensus between the non-professional and the professional in the setting for the ultimate benefit of the patient.

One means of decreasing stress and minimizing conflict is to increase the amount of information given to parents regarding the child's condition and treatment, the expected role of the parents and the staff, and the functioning of the unit. Inclusion of parents in the information network serves to remove uncertainty and facilitate the parent's definition of the situation. Information exchange also increases the likelihood of consensus between parents and staff regarding their definition of the situation.

Understanding on the part of parents regarding what is being done for their child serves to increase their trust and confidence

in the staff, facilitate their compliance and acceptance of the child's treatment regime and decrease opposition. Inital and on-going open communication regarding the role of the parent vis-a-vis the role of the staff in caring for the child allows the parent to more quickly define and locate their position within the system. When no mention is made to parents regarding their expected role in the setting, they remain uncertain and in stress and must then exert a great deal of energy and time in testing and negotiating their place in the setting.

The orientation of the staff, if made clear to parents on admission, allows the parent to either accept a role as defined for them by the staff or to negotiate in order to manage their role in a way that best meets their needs. A clearly defined role for parent and staff can serve to facilitate the work to be accomplished, minimize opposition between parents and staff and increase the probability of parent-setting fit.

The ideal of family-centered care in the pediatric in-patient setting necessitates the achievement of a parent-setting fit that results in parental inclusion and settling-in. Health professionals are in positions of established power and authority in the hospital system in relation to parents. Therefore, it is within their power to initiate and facilitate the process of parental inclusion into the health care system, and to assist the parent in the process of situational role management.

If the staff are to have and maintain an inclusion orientation this philosophy must be supported by the unit and the hospital. Support comes in the form of: a reward system that acknowledges staff work with families; adequate staffing to allow staff the time to operationalize their inclusion orientation; the provision of space and facilities for parents that symbolize parental acceptance and inclusion; and a visiting policy that allows parents access to the unit at any time.

The level of nursing personnel required on a unit that fosters parental inclusion and a share in the division of labor differs from that required in a unit that maintains an exclusion orientation. Nursing assistants are currently responsible for a great deal of the ward work in relation to caring for the child. The more parents are allowed to give this care, the less need there is for nursing assistants while the need for registered nurses is increased. The registered nurses would then be mainly responsible for the medical work, for providing information to parents, and assisting them to deal with the hospitalization experience and manage their role, activities which are not ordinarily within the realm of knowledge and skill of the nursing assistant. It also follows that a unit that is attempting to promote an inclusion orientation will receive the most resistance from the nursing assistants whose essential functions are being taken over by the parent.

To foster parental inclusion the staff must not simply re-align tasks to include parents but re-define their own role

as one of collaboration with the parents in lieu of competition. They become socializing agents for the parents, helping them to learn their role of parent-in-the-hospital. The structuring of the work to be done on the pediatric unit needs to be such that time is allotted for staff to work with parents. This function then becomes an integral part of the formal structure, rather than being left to chance or the informal structure of work.

Using the theory of situational role management as a framework for action, the staff can foster parental inclusion and facilitate parental progress through the phase of stress toward parent-setting fit and settling-in in several ways. The first step involves role clarity and the reduction of uncertainty. The role of the professional and the behavior expected of the parents as non-professionals needs to be made clear to the parents. Verbal contracts should be initiated by the staff to determine the place of the parent in the division of labor. It is suggested that information given to parents on admission be verbal as well as written. Any change in the child's condition should serve as a signal to staff to re-evaluate the parents' current definition of the situation and their role.

The staff should allow the parents a certain degree of flexibility in determining the amount of their inclusion on a performance level and be sensitive to parental desire to perform in light of a possible lack of skill or knowledge. Parents often inch their way into a place in the division of labor. If parental inching

is to be successful staff must reciprocate by yielding some tasks to the parents.

The emphasis of the staff should be on fostering the parenting functions and helping the parent and child to maintain their relationship throughout the experience. There is a danger of over-inclusion, involving the parents in the medical work to the extent that the parent becomes more of a nurse and/or doctor and less of a parent. When this happens, parents are so immersed in the technical aspects of care that they distance themselves psychologically and emotionally from the child, becoming objective and remote. This affects the parent-child relationship. The parent views the child more as a patient than as his child, and the child sees the parents as another doctor or nurse rather than his mother or father.

The staff can foster parenting by allowing parental accessibility to the child, thus providing the opportunity for the parent to nurture the child and maintain the parent-child relationship. Parents need to be given a choice and some control over when and where they will be present with their child.

One of the most important implications in relation to parental inclusion is the aspect of information exchange. Access to information and the ability to provide information to the staff helps the parents to maintain some control in the situation and fosters in them a sense of acceptance and inclusion. Staff can initiate parental inclusion into the information network by providing

information on admission. Time for parents to ask questions must be structured into the work. Parents are often intimidated by the health professional, it is therefore up to the staff to elicit questions from the parents, rather than assume that they will ask. Staff can ensure parental inclusion in the information network by making known to parents who the sources of information on the unit are, and what times of the day are the most appropriate for them to receive information. Another means of ensuring inclusion is to seek information from the parent and to involve them in the planning of the child's care.

On a unit that is accepting of parents, control over what occurs to the child becomes a shared responsibility of parents and staff. The legitimate authority of the parents over the child and their feeling of responsibility for the child are recognized and accepted by the staff. The parents are therefore told about the proposed plan of care and are kept informed regarding any changes in that plan. Procedures and treatments are explained to the parents in as much detail as is required for them to comprehend them. Parents are given credit for knowing their child as a person and are therefore given the opportunity to provide input as to what might be the best way to deal with the child in providing his care.

Differences between the naive and the knowledgeable parent in their situational role management have been elaborated throughout this study. This has implications for the setting of priorities

by the staff and for staff interaction with parents. Less staff time needs to be spent on admission with the knowledgeable parents who are more adept at defining the situation and their role. This time can then be used to work with the naive and inexperienced parent. On a day-to-day basis the level of information required by the knowledgeable parent needs to be more in-depth and medically sophisticated. The naive parent, on the other hand, will need more lengthy and detailed explanations and information and more clarification of medical jargon. Knowledgeable parents whose child is chronically ill need a greater degree of inclusion in the medical work than the naive parent. The treatment and care of a chronically ill child will carry over into the home setting and become an on-going part of that parent's role and function in relation to that child.

Parental inclusion results in satisfaction on the part of the parents in the management and performance of their role as parent-in-the-hospital. The family is strengthened by allowing the parent and child to go through the hospitalization experience as a psychosocial unit. The child receives strength and support from the parents and the parents are able to maintain their parental identity and broaden their repertoiere of parental behaviors. Parents who have had successful and satisfying experiences in the hospital setting may be more comfortable and better equipped to deal with health professionals in the future.

Although the majority of implications related to practice have to do with pediatric care in the in-patient setting, situational role management also has relevance for pre-hospital preparation. A great deal could be done prior to a child's hospitalization, if the admission is planned, to reduce uncertainty on the part of the parents. Nurses and physicians in the office setting if familiar with the situational factors as they exist in the various hospital settings, could then use this information in working with parents. Providing anticipatory counseling to the parents could possibly reduce their uncertainty, provide them with knowledge that would facilitate their definition of the situation, and increase their ability to arrive at parent-setting fit.

Implications for Further Research

No one research study can hope to deal with all the factors and processes of social life in a particular setting or environment. The researcher must at some point in his investigation determine the parameters of the study and decide which aspects of the social life are the most relevant to the emerging theory and relegate other aspects to the sidelines. This does not mean that these other aspects are less important, only that for the current investigation they are less significant in their bearing on the theory that is emerging. Also the researcher can say with assurance only that the discovered theory is applicable in the settings within which the study was conducted. Greater generalizability and certainty requires replication and testing of the theory in similar settings. There are therefore always limitations in the completed

study. Further questions can be raised that have not been dealt with due to the prescribed and necessary parameters of the investigation. The present study is no exception.

The parents interviewed for this study were those whose hospitalized child was between the ages of 18 months and four years of age. With increasing age the child's ability to deal directly with the staff and to make his needs known is increased. Although it is believed that the phases of situational role management are similar for all parents of hospitalized children, further investigation is needed to determine the effect, if any, of the child's age on the situational role management of the parent.

Both mothers and fathers were interviewed in this study and their behavior and response to role management within the setting was similar. However, not all fathers of hospitalized children spend time with their child or become involved in care for the child if they are present. Further study could elaborate on the reasons for this and determine whether it is due to: established parental roles prior to hospitalization; other role obligations of the father, such as employee; situational factors such as the staff's expectation that the mother rather than the father be present and involved in care, or the ability of the nursing staff, who are mainly women, to relate to and understand other women.

Although parent-staff interaction and the interplay between the family system and the hospital system were of prime importance

to this study, the focus throughout was on parental behavior. Investigation is needed to broaden the picture to include more in-depth analysis of staff behavior in relation to the parents and their effect on the staff's role in the setting.

An interactional framework was utilized in the process of analysis and conceptualization of parental behavior. Personality characteristics and psychological factors that influence parental behavior were not explained in this study. Investigation in this area would sure to broaden and expand the proposed theory.

This study was conducted in settings within which house officers were employed, and therefore it can be questioned whether there are differences, especially in relation to information exchange, in pediatric units where there are no house officers and only private physicians involved. It is not known whether parents in these settings are more or less included in the information network.

Parental behavior within the setting was the focus of this study. Research is needed in the area of the effects of the hsopitalization of the child on the entire family. For instance, what happens to the family functioning when the mother manages her role so as to spend all her time in the hospital? If the staff is to be truly family-centered in their approach there may be times when they need to help the parents to broaden their focus to that of the needs of the entire family versus only those of the hospitalized child.

In relation to the process of situational role management, parents in this study were differentiated according to their level of knowledge and experience with illness and hospitalization. Further study would determine the significance, if any, of marital status or ethnicity on parental role management.

Finally, it is the hope of this researcher that the theory of situational role management can be extended and proved applicable in situations other than the substantive area from which it emerged. This researcher believes that the concepts included in the theory of situational role management are of a level of abstraction that their generalizability to other situations of role management within organizational settings would prove valid. All families of hospitalized persons are faced with the problem of managing their role within the setting and attempting to become involved and included in the health care system. Although the degree of involvement on a performance level may vary with family members of an adult patient, it is proposed that the process of situational role management would have commonalities.

Any individual who embarks upon a new or altered role within an organizational setting that is unfamiliar to him, must take into account factors within the situation, such as those described in this study, that will have an influence on his role performance. Inclusion within the system and acceptance by others in the setting is not a foregone conclusion. Rather, the individual, new to a

position, must go through phases in his attempt to manage his role and become included within the system. It is suggested that the phases of person-setting stress, conflict and fit could be applicable in these situations and serve to explain the individuals role behavior. Application of the theory of situational role management within institutions could also be profitably used by management personnel in their attempts to socialize new members into the organization.

Summary

This chapter has summarized the theory of situational role management as it relates to the substantive area of parental behavior in the pediatric in-patient setting. The applicability of the theory by health professionals dealing with parents of hospitalized children has been discussed. Implications and recommendations for a family-centered pediatric unit that fosters parental inclusion have been presented. Finally, limitations of the study have been presented and areas for further research have been identified as well as the possibilities for a more general application of the theory to other situations of role management.

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APPENDIX A

Parent Consent Form

Parent Consent Form

University of California San Francisco
Consent to Act as a Participant
In The
Study of Parents in the In-Patient Pediatric Setting

I agree to have Ms. Betty Kurczynski, a candidate for the Doctorate of Nursing Science degree at the University of California San Francisco, ask me a series of questions about parents of hospitalized children. I have been informed that the purpose of this research is to determine the various factors that influence parental behavior in the hospital setting. These questions, in the form of an interview with the use of a tape recorder, will take place in the hospital settingat a mutually agreed time. I understand the interview will be approximately one to one and a half hours in length and that additional interview time may be necessary.

I understand that my participation in this study is entirely voluntary. I understand that I may refuse to answer any of the questions aksed or may end the interview at any time without any penalty and without any jeopardy to myself or the care of my child.

I understand that as a participant in this study there are minimal risks to me. I understand that discussing the hospital experience may cause some stress. I further understand there may be no benefits to me personally, but the information given will mean better understanding of nursing care of families in the hospital.

I understand that my responses will be kept confidential and that every precaution will be taken to safeguard the anonymity and trust of those persons who consent to participate. In addition, Ms. Kurczynski has informed me that I will be in control of the tape recorder and that I may turn it off at any point during the interview.

I understand that I will not be compensated for my participation in this study.

If I have any questions regarding the study before or after the interview, I may contact Ms. Kurczynski by calling 931-7878, or leaving a message with Ms. Mary Ann Halstein at 666-1504.

Date_____ Signature_____

APPENDIX B

Staff Consent Form

Staff Consent Form

University of California San Francisco
Consent to Act as a Participant
In The
Study of Parents in the In-Patient Pediatric Setting

I agree to have Ms. Betty Kurczynski, a candidate for the Doctorate of Nursing Science degree at the University of California San Francisco, ask me a series of questions about parents of hospitalized children. I have been informed that the purpose of this research is to determine the various factors that influence parental behavior in the hospital setting. These questions, in the form of an interview with the use of a tape recorder, will take place in the hospital setting at a mutually agreed time. I understand the interview will be approximately fifteen to thirty minutes in length, and that additional interview time may be necessary.

I understand that my participation in this study is entirely voluntary. I understand that I may refuse to answer any questions asked or may terminate the interview at any time without any penalty and without any jeopardy to my professional employment.

I understand that as a participant in this study there are minimal risks to me. I further understand that there may be no benefits to me personally, but that the information given will mean better understanding of nursing care of families in the hospital.

I understand that my responses will be kept confidential and that every precaution will be taken to safeguard the anonymity and trust of those persons who consent to participate. In addition, Ms. Kurczynski has informed me that I will be in control of the tape recorder and that I may turn it off at any point during the interview.

I understand that I will not be compensated for my participation in this study.

If I have any questions regarding the study before or after the interview, I may contact Ms. Kurczynski by calling 931-7878, or leaving a message with Ms. Mary Ann Halstein at 666-1504.

Date_____ Signature_____

APPENDIX C

Interview With Parents Format

INTERVIEW WITH PARENTS (Initial Format)*

A. DEMOGRAPHIC DATA

1. Age (both parents)
2. Ethnicity (both parents)
3. Educational level (both parents)
4. Occupation (both parents)
5. Income
6. Family composition - age of siblings
7. Previous experience of family with hospital or health care system
8. Hospitalized child:
   a. Age and sex
   b. Illness
   c. Length of stay
   d. Previous hospitalization
   e. Other separations of child from parents

B. INTERVIEW

1. What is it like for you having you child in the hospital?

2. What amount of time do you spend here? What do you do for and with your child when you are here? How is that different from what you do at home?

3. What kinds of information do you think is important for you to have? How do you get that information?

4. Tell me about the day your child was admitted. How did you feel? Have your feelings changed since then?

5. What do you expect of the staff? of yourself in the hospital? Have your expectations changed since you've been here?

6. Tell me about the staff you are most comfortable with?

7. How do you react when situations arise such as:

   When you are not sure what someone is doing to your child?
   When you are asked to leave the room or unit?
   When your advice is asked about the care of your child?

8. Whom or what has been helpful to you while your child has been in the hospital?

9. Can you tell me one or two positive things and one or two negative things about having your child in the hospital?

INTERVIEW WITH PARENTS (continued)

10. Could you describe what you would consider an ideal situation for parents in the hospital?

11. Is there anything else relating to this hospital experience that has not been covered that you would like to share with me?

*This initial interview format was subsequently altered in the course of the study as a result of data analysis and emerging theoretical formulations.

APPENDIX D

Interview With Staff Format

INTERVIEW WITH STAFF (Initial Format)*

A. DEMOGRAPHIC DATA

1. Age
2. Sex
3. Education

B. INTERVIEW

1. What is it like for you when parents are here with their children?

2. In what ways does having the parents here make your work easier or harder?

3. What do you think parents should do when they are here? What kinds of things do you expect from them?

4. Tell me about the parents you are most comfortable with.

5. Are there specific situations when you prefer to have parents here and specific situations when you would rather they were not here?

6. What kinds of information do you feel comfortable in giving to parents? What are your sources of information?

7. Can you give me one or two advantages and one or two disadvantages of having parents here?

8. What do you find most satisfying in your work?

*This initial interview format was subsequently altered in the course of the study as a result of data analysis and emerging theoretical formulations.