The Captive Mother*

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It was a Friday night in autumn. In the children's ward the mother who had come to live with her retarded child was crying. The house physician listened to her: she hated it in hospital; she was worried about her other children at home; she had had an argument with her husband earlier that evening; she wanted to go home. Couldn't she go home for the weekend, asked the house physician. 'Oh no, how can I?' she replied; 'Doctor M said it would help Robert my being in with him and after all that he has done for me and Robert the least I can do now is stay.'

It is easy to talk mothers into coming into hospital with their children. It is much less easy to make sure that their stay will be happy.

The existing accommodation for resident mothers is limited; while a few hospitals have plentiful accommodation, most of them have rooms for only one or two mothers and many have no rooms for mothers at all. New children's wards are being planned and built throughout Britain. Provisions for resident mothers are being improved and increased each year; many new units are aiming to achieve the recommendation of the Nuffield Foundation study group (1963) that a 20-bed children's ward should have 8 separate rooms in which mothers can stay if necessary.

That the mothers will use the rooms has been shown by experience in Newcastle (Court, 1963), Amersham (MacCarthy, 1963), Brighton, and other hospitals which have invited large numbers of mothers to live in.

In areas where there are inadequate facilities for mothers to stay in hospital with children, it has been found that nearly half of all mothers would like to accompany their child of under 5 years to hospital, and this proportion seems to be regardless of social class or area (Meadow, 1964). The factors that reduce to a third those mothers who are able to go into hospital with their child include the number of other children at home and the mother's job. Another limiting factor could be the attitude of doctors. However, the tendency is for more doctors to encourage mothers to accompany their children into hospital; the Nuffield Foundation (1963) survey showed that the majority of paediatricians were in favour of the practice.

The accommodation will be available; doctors will encourage it; mothers will accept it. The fear is that hospitals and their staff will merely 'accept it' too. After meeting several mothers with strong opinions about the care they received in Mother and Child units, I carried out a survey over a 2½-year period to find out what mothers felt about their stay in hospital, and during the same time the medical and nursing staffs of the wards were asked for their views.

The mothers were a sample of those admitted with their child into three different hospitals. All 130 were interviewed while in hospital, and 60 were reinterviewed subsequently in out-patients on one or more occasions. The admissions were equally divided between medical and surgical; two-thirds were routine elective admissions, one-third were emergencies. The views of mothers differed little according to the type of admission.

The quality of the information varied and did not correlate with whether or not the mother knew me. About a third of the mothers knew me, to others I was a complete stranger, and to some a vague registrar doctor figure who had helped in their child's care. The interviews in the ward were deliberately informal. There was no questionnaire, the mothers were encouraged to talk about their stay in hospital, and nothing was written down in
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their presence. It was usually possible to steer
the conversation towards the aspects of hospital
care which are reported. Most of the mothers
had something to say about each of the topics.
The strongest impression gained from these
conversations is of the mothers’ exquisite boredom
during their stay in hospital. With no meals to
prepare, no shopping, no walks to the park, and
no housework, the mother finds herself cooped up
in an uncomfortable room with her child for 23
hours a day. It is a totally false situation. The
idea of coming into hospital with an ill child
sound
ed good to her, and the idea of catering for
his every need, playing with him all the time,
seemed excellent. But outside hospital the mother
isn’t doing this: she isn’t playing with and pander-
ing to her child all the time even when he is ill.
Normally her child is contented playing out of
her sight for long periods, and he may spend part
of the day with relatives or with friends. He is
happy away from her provided he has the security
of knowing that when he needs his mother she
will come. In hospital the same condition often
applies, and all that may be needed is that the
mother is somewhere within the hospital. The
normal relationship is altered when suddenly the
mother is thrust into the sole company of her
child in a strange uncomfortable hospital with
nothing to do and surrounded by bland staff
who treat the situation as if it is the most natural
thing in the world. Most mothers are desperately
bored and look forward to discharge from hospital
as if to the end of a long prison sentence.
All that follows has to be viewed in the context
of this boredom. Because of boredom and a mind
no longer occupied with everyday affairs, many
normal emotions and worries loom much larger
than life. Some mothers recognized this, and when
interviewed again after their stay professed how
much less strongly they felt about the topics they
had discussed with me in hospital. More than
one said she was so worried about her child that
she was really mentally ill at the time. Certainly if
information had been solely gathered retrospec-
tively it would have been less fully and much less
colourfully expressed. But it is the impressions
of mothers while they are in hospital that matter,
for it is at that time and while their children are
ill that we encounter them.
Mothers in hospital may be short of household
affairs to occupy their minds, but they still worry
less about the sick child than if they had stayed at
home. Only 20 of the 130 mothers said that
coming into hospital made them worry more; of
these, some were particularly squeamish or worried
about apparatus, while others were upset by ill
children in the ward particularly with infusions
running or drains in place. 108 of the mothers
were certain that they worried less through being
with their child. It is relevant that nearly half had
previously had a child in hospital—but unaccom-
panied. They worried less mainly because they
could see the child was there and, however ill, was
alive; they saw him alive immediately on return
from the theatre; they saw him comfortably asleep
while the blood transfusion was being given. At
home they would have been worrying about what
was happening. Some worried less because of
being sure their child was being understood:
‘If I was at home the nurses might not have known
she wanted the pot.’

Although worrying less than if they were at home,
most had a lot of worries that they might not have
had at all had they not been living in hospital.
When asked about specific diseases they worried
about, 46 mentioned a particular disease, and of
these 30 feared leukaemia, though in only one
case did it feature as even the vaguest medical
possibility. Leukaemia seems to be the current
national fear, and fear of it was brought about by
seeing their children have blood tests: ‘They
never told me if it was normal,’ and ‘It must have
been because they suspected leukaemia.’

Many of the minor worries were related to
investigations their child had and lack of explanation
about them. This is a difficult problem. It is
questionable if sharing with a mother the complete
list of differential diagnoses is going to help her
worry less. What can be done is to explain the
routine investigations, for instance haemoglobin
and urine tests, and, most important, to report back
when they are found to be normal. It is deplor-
able when, as was found, a mother whose infant
has coeliac disease and another whose child has
had bat ears repaired are worrying about leukaemia
for over a week in hospital.
The worries are difficult to define because we
are too sophisticated: the fears often do not make
medical sense to the doctor or nurse. One mother,
whose 2-year-old child had had an inguinal hernia
repaired, complained 6 days later: ‘They’ve still
told me if it was malignant.’ Another said:
‘I wish they would tell me why he has a temper-
ature; do you think it is a kidney infection?’
The child’s temperature chart showed a rectal
temperature of 37.5 °C. (99.5 °F.).

Worries are dispelled by listening and by pro-
viding more information. All except 6 mothers
said they had too little information, but a great
many, discussing this, pointed out that when you
are alone in a room with your ill child there is no such thing as enough information. About a quarter of the mothers really felt they had been told much too little, and it was clear that they had been poorly informed. Over half of the children concerned were in for surgical procedures, and it is in this sphere that the medicine of television and the actualities of the mother and child cubicle gaping furthest apart. The mothers long for definite news of the operation, for the surgeon or anyone to come along grandly and say, 'I circumcized him, everything went according to plan.' Even if the operation is for the removal of a birth mark under local anaesthetic, they still hope a member of the surgical staff will come and tell them of the success of the operation. What usually happens is that the staff automatically assume that all routine procedures go according to plan, and it is only when things have gone wrong that the operation is discussed with the mother.

As well as the 'result' of the operation they would like more definite information about the day their child can expect to go home. This is even more important than usual when the mother is in hospital because of her feeling of imprisonment and because of the home arrangements she may have had to make. She wants someone to say, 'If all goes well, he will probably be able to go home next Tuesday.' In 10 surgical cases the mother did not have any idea when her child might be going home, and badly wanted to know; in all except one case the staff could have named the actual discharge day with 95% probability.

If mothers are worrying and are living on the ward, why don't they ask one of the numerous staff for the information they so much want? The answer is not clear: the mothers themselves didn't always know why they hadn't demanded more news. Much of their difficulty lies in the power and authoritarian structure of hospitals. The mothers have all the inferiority of anyone in a strange place—on one's first day at work or a visit to a foreign country. As will be seen later, all too often very little is done to put them at ease in this strange situation. Many mothers said that they voiced their worries and asked their questions only to the ward orderly or the most junior trainee nurse. They were taking their medical problems to the only two people in the ward without the medical knowledge and authority they needed. The mothers were not bitter about this; they were resigned to the fact that information was a rare commodity, and several seemed to think that doctors and nurses worked so very hard that there was not time left for discussion.

Several mothers failed to question the staff because of a feeling of being on trial. Some, particularly if the child's illness was linked with failure to thrive, behaviour disturbance, or developmental problems, felt guiltily responsible for the child's trouble. They come into hospital very much on trial, aware of many eyes watching them, and so have difficulty in establishing a warm relationship with the staff. It also prevents them from acting normally towards their children, either in anger or happiness. At times when several mothers are in who have this feeling of being on trial the tension rises as a result of being with the others. One mother told of three successive meals in the mothers' little dining room at which all of the six resident mothers had burst into tears as soon as they got away from the ward and into the dining room.

Very often we, the staff, discourage their approaches. Every doctor will recognize the brutal poignancy of the remark, 'When we arrived he spent 2½ hours listening to me and examining Gary, but after that he never spent more than 30 seconds with us again', or the mother of a child with diabetes who complained that the doctor, who had spent a long time on admission asking about the family history, showed no interest at all when she went up to him 3 days later to report that she had just remembered that her husband's cousin was a mongol.

Throughout their stay, however, it is boredom that dominates everything. The conscientious mother who does everything possible to help her child and other children in the ward is still left with a very empty day compared with home. The failure of the staff to recognize this doesn't help.

Resident mothers are sometimes criticized for being lazy, untidy, or for leaving all the nasty things for the nurses to do. Everyone working in a Mother and Child Unit has their own favourite recollection of a particular mother—the model who comes in with 34 jars of make-up, spends her time prinking, and demands from the nurses a hotel type of service, or the journalist who efficiently cleans the cubicle and child, then sits in a corner all day writing and never talks to or plays with her child. Everyone in these units also knows that such mothers are the exceptions, and that the rest are anxious to help their child and the ward in general. 114 of the 130 mothers would have liked more definite information about ways to help. They are uncertain of their role: of what child care, ward work, and helping they are meant to be doing or even allowed to do. One mother felt
like a child on her first day at boarding school; only in this case there is no rule book and the only written information is 'Mothers are requested not to smoke'.

Most hospitals have a helpful booklet which is issued when a child is admitted. Many of them are useless to the resident mother; she needs a special booklet of her own containing detailed information about ward life and her place in it. A lot of misunderstandings would not arise if the booklet was well devised. Routine investigations could be explained, the best times to discuss problems outlined, and very important, it could be made clear that the mothers are not expected to be in the cubicle for 23 hours out of the 24, 7 days a week. More than one mother thought she was 'only allowed out of the cubicle at meal times'. Even at Holloway they get exercise. Mothers should be encouraged to go home and visit their families, or to go out to the cinema with their husbands.

A booklet could also give details of the available facilities: where they can wash their clothes, where they are allowed to smoke. The comforts of Mother and Child units are few, and, though mothers rarely complained about lack of comfort, all had suggestions for improvement. 'It's too hot' (from central heating) and 'it's too noisy' may not be easy to correct, but other things are. Sometimes when a mother is in a cubicle she has to undress in full view of anyone in the corridor: simple screens would help. Hospitals with room for several mothers often have a sitting-room for them; this is appreciated, but if there is no television it is hardly home.

30 mothers specifically mentioned their longing for television to relieve the monotony. Some comforts can be provided easily, once it becomes someone's job to go round finding out what is needed. Other improvements will require money. The mothers would be glad to contribute: several of them at some stage in the discussions said they were surprised that no charge was made for meals. 70 out of 70 mothers asked, said that paying 10/- a week would not have made any difference to their coming in, and that they would have liked to have paid it if it would improve amenities for future mothers.

Mothers in hospital have many problems: the hospital staff, though they did not comment so forthrightly, have just as many problems in coping with them.

As the Nuffield report showed, consultant paediatricians are in favour of the admission of young children to hospital with their mothers. This probably applies to consultants in other specialities as well. Though E.N.T. consultants have been among the slowest to allow resident mothers, a recent report (Brain and Maclay, 1968) of less emotional trauma and infective complication in 200 children admitted for E.N.T. surgery with their mothers suggested that even in that speciality opinions are changing.

For the paediatric consultant, resident mothers are nice to have about. He is no longer just a name on the case notes, he is seen to be doing his job and gets to know mothers he might not otherwise meet. Because he likes resident mothers, and knowing of their great value to the child in hospital, there is a risk of his over-persuading mothers to come in; a paediatrician can often persuade the mother to do exactly what he wants. More dangerously, when he is not intending to be over-persuasive, the parents are so anxious to please him that they will agree to his plan when it does not suit them. 'If you had ever sat opposite Doctor X when he suggested that it was nice for a child to come into hospital with his mother, you wouldn't dare say you wouldn't.' This means that the paediatrician, in giving his views, must be sure to give the alternatives as well, and then to leave the parents time to make up their own minds. Many parents do not realize that all-day visiting is routine in most modern children's units, and for some mothers the immense difficulties of making arrangements for the other children outweigh the advantages of being resident. 'I would never have come in if I'd known I could visit all day anyway.'

In brief, consultants seem pleased with the admission of mothers to hospital with their children; not all appreciate the nicer difficulties that the mothers have, and few have worked in these units in a junior medical or nursing capacity.

The opinion of junior medical staff about resident mothers is summed up by an H.P.'s remark: 'They're a bit of a bind.' They are time-consuming and need more explanation. There is misunderstanding when the houseman putting up a difficult drip would prefer to be unobserved, while the mother stays because she feels she would be failing if she sat outside. All the same, many housemen had enjoyed getting to know the mothers, but qualified this by saying that they did not have to live with them in the same way as the nurses did. They accepted resident mothers somewhat neutrally, and with them they accepted the extra work involved; for them there was no issue of status or authority as there is with the nursing staff.

The attitude of the nursing staff cannot be defined
simply, and in any case must vary greatly between the experienced Sister who has run the ward for 30 years and the young Sister with her first ward. Without exception all nurses approached were in favour of the principle of resident mothers. But as one Sister said, 'In 1966 no children's nurse would dare say she wasn't.' In practice there are difficulties. The difficulties are greater for the old-fashioned (not necessarily old in years) nurse who is better at didactic advice for the unskilled than at being subordinate to an intelligent mother. 'You're learning quickly, mother' said one Sister, 'you changed his nappy well; if you do as well tomorrow I'll let you help me take his temperature.' The mother concerned, a sociology graduate with other children, commented that it reminded her of the day at school when she won the Helpfulness Prize. Some nurses have an authoritarian approach which, helpful to some mothers, is disastrous for others; and they find they cannot change the technique of a lifetime. Very few nurses seemed to believe that a mother is better at looking after her child than a nurse; and yet an efficient and successful Mother and Child unit, with a mother doing most of the child care, carries this implication with it.

The authority of the nurses is usurped to some extent by the mothers. No longer does the consultant say 'and how is he feeding, Sister'; instead, there is, 'Hello Mrs. Barnes, did Roddy feed normally today?' In this and other ways the Sister is more subordinate to the mothers than when they live out. One way for the consultant to get over this difficulty, and to show that he recognizes that care is still shared and Sister's opinion valuable, is to do a round of the case notes in Sister's office before going round the ward and talking to the parents; in this way Sister has her say.

Nursing in a Mother and Child unit is different qualitatively and quantitatively from nursing in an ordinary ward. Nurses who recognized that they now shared the care of the child with the mother said it meant it wasn't as rewarding as without the mother. The fact that more than half the nurses said that resident mothers on the ward created more work was not dependent on the acknowledged fact that resident mothers needed more explanation. Half the nurses actually thought that it was harder work when mother was there to help. This is incredible when nearly all the mothers say they are anxious to help in the care of their child and in work of any sort on the ward. The system is faulty—perhaps in the training of nurses, perhaps in ward administration, most likely in both.

The picture of the captive mother in hospital with her child has been described, together with some of the difficulties. These should not be exaggerated, because though many of the mother's comments showed up shortcomings in the hospitals, the fact remains that 96 of the mothers said they would want to come in again with a sick child. Of the 34 mothers who would not go into hospital again, 12 said it was because with completely free visiting they thought they could be there almost as much as when living in, 5 said they were now much less worried about what happened to children in hospital, and 5 had found their other children at home were too distressed by their absence.

Talking to the mothers later in out-patients, many said how much they gained by the visit. Some felt more confident at looking after an ill child, several had the pride of having put up with something unpleasant for the sake of their children, and the pride of having been one of those to help the child get better. Others mentioned the absence of upset when they got home compared with previous unaccompanied visits to hospital.

The mothers rightly had criticisms, but the units should console themselves with the fact that they are providing a service, albeit imperfect, for which the mothers are very grateful. Now is the time to start improving the service and plan for better new Mother and Baby units. Many ways have been suggested in which the resident mother may be made happier and more useful. When admission is suggested they need more detailed information about that particular hospital and then must be given time to think about it before making a decision. They should be able to look round the accommodation for mothers beforehand. When they come in they need a special Resident Mothers' Booklet of guidance containing rules and information. They should be told what to do for their own child, and invited to help with other children and share the domestic duties of the ward. Their rooms and their comfort can both be improved easily with or without financial contribution from them. Nurses must be trained in how to share care with a resident mother and how to use her as an efficient and willing source of labour. Doctors need to recognize the very real difficulties which mothers may provide for the nursing staff; and they must also recognize the extraordinarily artificial and difficult position of the captive mother, and give her the sort of thought, attention, and information she wants.

Improvements of this kind are not costly; with a little trouble they can be implemented anywhere. The problems behind them are not unique to the situation of the mother resident in hospital with
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her child: the same needless worries, the same communication difficulties, the same inflexibility can be found throughout the Health Service. For the resident mother, uncertain, frightened, worried, and yet not ill herself, they just seem worse. It should not be difficult to make the lot of the resident mother more useful and more happy, but it will require sensitivity, imagination, and effort from doctors and nurses.

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