The doctor, the father, and the social scientist

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Life was sorted. With membership of the college under my belt, and my paediatric training completed, I needed a new challenge. I decided to launch into the deep waters of qualitative research. Stepping out with some trepidation into semistructured interviews and grounded theory, I soon found that the water was neither as deep nor as unknown as I had feared.

As a paediatrician I have long been fascinated by parenting, what constitutes parenting, and why it sometimes goes wrong. As a father the last question shifted to why it doesn't go wrong more often. In the words of one of the mothers I interviewed, "Some people seem to think that you just have children, you bring them up and that's it. But it doesn't work out that way. It's hard." My dual roles thus set the basis for my research, a study of parents' views of parenting, its highlights and stresses, and how and why it can go wrong. The topic seemed to lend itself to a qualitative approach, but, like many doctors, this struck me as straying into unfamiliar and potentially dangerous territory. Armed with a few key texts,^{1–3} I slowly became acquainted with a new language. Then, having struggled through the turbulent shallows of designing and piloting the project and obtaining ethical approval, I finally started interviewing. From the beginning I enjoyed the interviews but as the study progressed, I found that my approach altered. I increasingly noticed a number of similarities to my clinical approach to patients.

As a medical student learning to take a clinical history, I was taught a clear structured approach to elicit all relevant material (presenting complaint, past medical history, family history, review of systems, etc).⁴ As my experience and confidence grew, I retained the basic framework, but incorporated an increasing flexibility, accommodating the patient's (or their parent's) narrative approach. In a similar way, as I became more familiar with this interview, I relied more on the parents taking the lead, returning to the framework at points where they dried up or to bring in subjects which hadn't automatically been raised. Subconsciously I think I drew on techniques commonly used in clinical practice: using open rather than closed questions; "reflecting back" to the parents what they had just said, to check if my interpretation was accurate; acknowledging the validity of the parents' responses.^{5–6} For example, in the following extract I acknowledge the value of one mother's observation, while the second extract gives an example of reflecting back, to encourage further elucidation:

Mother: And I just think they're not having a chance to be children ... sort of ... growing up quicker ... I just feel this is why we get more teenage families cause they're growing up quicker and ... then that's my view I don't know if that's ...

Me: Yeah that's right ... I've not actually thought of that in that light before ... I think there's something in that isn't there?

Me: You sort of mention that there's all these expectations and so on, do you think people, I mean apart from their own parents, would see, tend to see children in a positive light or a negative light or ...

Mother: I think, because people are trying to have them grow up ... I think, I suppose you're just hurried along really aren't you, you forget about the fact that they are just children ...

My identity as a paediatrician and the sensitive nature of the research brought both potential conflicts and advantages in relation to my role as a researcher.⁷ The status of a paediatrician could be interpreted negatively, or seen as intimidating by some parents, particularly given that most of the parents interviewed were mothers, and I, a white, middle class male. It is possible that this influenced the degree to which parents were open with me, although there was only one interview in which the mother did seem to be uncomfortable and perhaps guarded in her responses. In spite of this conflict, I thought it was essential that I was honest about my professional role. In fact, my impression was that this, if anything, lent some credence to my role as a researcher. I was able to introduce the research in relation to my clinical practice, that I was wanting to understand parenting from the parents' viewpoint in order to inform my practice and help with my understanding of the sorts of problems and issues I face as a paediatrician. In a sense it gave me a legitimate right to ask the questions rather than the research being seen as prying or simply for my benefit.

As a father too, I felt that my role as a researcher was enhanced. I was able to draw on my own experience in empathising with the parents and in the process of acknowledgement. Indeed, several of the parents seemed to test out my validity as a researcher early on in the interview: once they discovered that I too had children, they seemed to relax a bit and become more open in their responses. Although I was meeting these parents for the first time and therefore coming into the research without any established rapport, I found that my role as a father did facilitate the development of rapport with the parents.

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The seas of qualitative research are not however without their sharks. I think I came out of this research with more questions and less certainty about any answers than when I started. Focusing on a small number of subjects is rewarding in the depth of data you get, but you inevitably wonder how representative your work is: what about the fathers I didn't interview? Would younger mothers, those from different ethnic backgrounds, those living in council estates, have different views? Coming from an evidence based medical background, I found it difficult at times to believe in the validity of my results: how can 16 interviews possibly convey a true picture of the nature of parent-child relationships? What about the biases introduced by the voluntary nature of the study, or by subconscious social desirability, or my own influence on the interviewees? In this respect too, the qualitative approach probably reflects more of the reality of clinical practice, in which we are rarely dealing with certainties or complete pictures.

Overall though, I have no doubt that my paternal and paediatric roles both added to my new venture, but the converse is also true. Even though the number of interviews was small, I have learnt a lot about parenting that I might never have encountered through my personal experience or professional practice. My background reading for the project has exposed me to a wealth of information on children's development and needs.⁸⁻¹⁰ Taking a structured look at interviewing techniques has in turn influenced my clinical approach.³ In particular, I think I am more reflective and more flexible in dealing with parents, perhaps being more questioning of whether I have truly understood what they are saying, or the meanings behind that. Finally, some of the results coming from the

research have challenged my perceptions of parenting, its stresses and rewards.¹¹ At the most basic level, it has acknowledged that my experience of parenting is not that different from that of other parents. As one mother expressed: "it is hard work, it's really hard work ... but you know, I mean the love that they give you, I mean for what you give them, they give it you back ten fold".

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Music for preterm babies

Music soothes, and the existence of the lullaby is presumptive evidence that mothers have always, or nearly always, believed that it can quieten babies. For over a quarter of a century evidence has accumulated that music might improve the physiological responses and growth of premature infants. Such infants are often subjected to levels of noise which cause concern but the special properties of music may make it beneficial. A meta-analysis (Jayne M Standley. *Journal of Pediatric Nursing* 2002;**17**:107-13) has given support to the view that music is good for premature infants.

Ten studies met predetermined inclusion criteria. (The meta-analyst was author or co-author of six of these studies.) Six studies used recorded, free-field music, usually lullabies, three used recorded music through earphones, and one used live singing. Music at 55 to 80 dB was associated with improvements in behavioural state, heart rate, respiratory rate, oxygen saturation, weight gain, feeding rate, non-nutritive sucking rate, and duration of stay in hospital.

The author of this meta-analysis recommends lightly rhythmic music with unaccompanied voice or voice plus one instrument, constant rhythm and volume (low seventies dB), and no more than 1.5 hours per day, alternating 30 minutes on with 30 minutes off. Live singing of lullabies she regards as excellent but she definitely disapproves of music-generating toys or mobiles.