CONCEPT ANALYSIS

Family-centred care of children in hospital – a concept analysis

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Abstract

Aim. This paper reports a concept analysis of family-centred nursing care of hospitalized children.

Background. Family-centred care describes a practice aimed towards involving the family in all aspects of care. Previous analyses explore the colloquial use of the concept. An increasing amount of scientific papers apply the concept with seemingly little consistency in use.

Data sources. A systematic literature search including articles from 1951 to 2009 resulted in a sample of 25 research articles.

Review methods. A theoretical concept analysis influenced by Risjord’s distinction between theoretical and colloquial analyses and based on the principles developed by Morse, Hupeyc and Penrod was used to examine the structure and scientific maturity of the concept.

Findings. There is good agreement on the defining attributes of the concept, but they are described by sub concepts in need of clarification. The relationship between family and professionals is characterized by a mutual dependency and shared responsibility for the child’s care, which may have both positive and negative consequences and holds potential areas of conflict not fully explained by the attribute of partnership. The nature of partnership remains unclear and it may therefore not yet be a relevant attribute. The concept is defined from the perspective of professionals and families, mostly represented by mothers. Few attempts have been made to operationalize the concept.

Conclusion. Family-centred care is a partially mature and highly abstract concept. Developing a theory of family-centred care could position the concept in a theoretical context and should also include the perspective of the sick child.

Keywords: children, concept analysis, family-centred care, family-professional relations, nursing, parents, partnership

Introduction

Since Bowlby and Robertson in the early 1960s demonstrated the negative consequences of hospitalization for the psychological well-being of children, recognition of the family as a unit increased (Alsop-Shields & Mohay 2001). Internationally, the concept family-centred care (FCC) became widely used to describe a practice that recognizes the family as the fundamental source of support and considers the deliberate involvement of the family essential to promote the health of
all family members (Franck & Callery 2004, Shields et al. 2006). Although rooted in the western culture, an awareness of the basic elements of FCC in both developed and non-developed countries has been identified (Shields & Nixon 2004), underlining the global relevance of the concept.

Family-centred care is viewed as a paradigm (Hall 2007), a philosophy (Malusky 2005), a model of care (Shields et al. 2007) or as a practice-theory (Hutchfield 1999). Several authors have solicited an operationalization of FCC to increase its efficacy in nursing practice and research and to meet the current demand for evidence-based practice (Hutchfield 1999, Franck & Callery 2004, Hall 2007).

According to Morse et al. (2002), concepts form the link between theory, practice and research and require a clear scientific definition of the concepts in use, which in turn can form the basis for operationalization and use in practice. As suggested by Risjord (2009), we differentiate between theoretical concept analyses that represent concepts as they appear in scientific literature and colloquial concept analyses that represent the concepts of a particular group of people. In this paper, we focus on the scientific use of the concept family-centred nursing care of hospitalized children and adhere to the separation suggested by Franck and Callery (2004). They observed a tendency to use the term ‘family-centred services’ for care of children with special needs, i.e. disabilities whereas FCC is used mainly in the acute hospital care setting. We therefore present a theoretical analysis of the concept as it appears in scientific studies in a hospital context.

Background

An increasing number of papers on FCC have been published in the last decade. However, a recent meta-analysis was unable to conclude on the effectiveness of FCC compared with other care models due to the lack of eligible studies (Shields et al. 2007).

A substantial amount of the research on FCC reflects challenges related to its implementation in practice. Several authors report that nurses support the philosophy but have difficulty integrating the principles into their daily practice (Bruce et al. 2002, Petersen et al. 2004, Palladellis et al. 2005). These difficulties have been explained by others as a theory-practice gap (Franck & Callery 2004, Hall 2007). Since 1993, concept analyses of FCC using different approaches have indicated a lack of a clear definition and suggested that different understandings of FCC occur in different settings.

Hutchfield’s (1999) evolutionary analysis based on Rodgers method identifies two views on FCC; a holistic and a functional and presents a hierarchical model beginning with parental involvement and culminating in FCC, which therefore in its fullest sense is only present in some cases.

Using Walker and Avant’s method, Malusky (2005) identifies similar characteristics to Hutchfield but discusses no negative consequences whereas Hutchfield questions the relevance of implementing FCC in all situations.

Nethercott (1993) also uses Walker and Avant’s method in her analyses of FCC of hospitalized children, and argues that FCC is rooted in theories, seeing the family as part of an individual’s environment or as a system; and care should thus be aimed towards the needs of the family as a whole.

Neither of the analyses address the role of the concept in nursing science or its usefulness for research purposes. Furthermore, two of them employ the method developed by Walker and Avant, which Hupcey and Penrod (2005) criticize for not presenting a scientific examination of concepts.

According to Morse and colleagues, the degree of maturity determines the usefulness of a concept. A mature concept is well-developed when consensus on its definitions and application is reached among researchers, practitioners and theoreticians (Morse et al. 2002).

We found it relevant to study the current conceptualization of FCC due to increasing ambiguity and different conceptual interpretations in the scientific literature on FCC published since Hutchfield’s study in 1999. We therefore performed a theoretical concept analysis, as defined by Risjord (2009), in nursing research.

The method is based on the principles developed by Morse in collaboration with Hupcey, Penrod and Mitcham (Morse 2000, 2004, Morse et al. 2002, Penrod & Hupcey 2005). The steps involved in the analytic process are shown in Table 1.

The choice of analytic strategy implies a certain ontological and epistemological position. In this paper, we adopted a view that agrees with Hupcey and Penrod’s standpoint of moderate realism. Concepts here are seen grounded in reality because they are based on the individual’s empirical

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**Table 1** Steps for concept analysis as interpreted from Morse and colleagues

- Review of disciplinary literature
- Conceptually driven sampling evaluated by adequacy and appropriateness
- Sorting and coding of data according to concept components of definitions, preconditions, attributes, outcome, boundaries and application
- Identification of themes and comparison with literature sample
- Synthesis and integration of results into a theoretical definition

Table 2 Search strategy

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
<th>Databases</th>
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</thead>
<tbody>
<tr>
<td>Peer-reviewed</td>
<td>Family-centred service</td>
<td>1. CINAHL (1981–2009)</td>
</tr>
<tr>
<td>Empirical research or theoretical report based on a systematic review</td>
<td>Not hospital context</td>
<td>2. Medline (1951–2009)</td>
</tr>
<tr>
<td>Availability from library</td>
<td></td>
<td>5. Aarhus University Database</td>
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</tbody>
</table>

experiences with a given phenomenon. Through cognitive processes, a mental abstraction takes place, which is influenced by the individual’s contextual circumstances. It is possible to examine and integrate these contextually based conceptions by using techniques for concept analysis and thus reveal what can be considered the best estimate of truth or what Hussey and Penrod call ‘the probable truth’ (Hussey & Penrod 2005, p. 201). However, concepts may change over time and as pointed out by several authors, the meaning of a concept is closely linked to the theoretical context, in which it is used (Paley 1996, Morse 2004, Penrod & Hussey 2005, Duncan et al. 2007, Rijnd 2009).

Data sources

The following databases were searched: CINAHL, Medline, Scopus, SweMed and Aarhus University’s database of internally published theses, including data from the start of each database to 2009. The results of the literature search are given in Table 2.

Keywords were family-centred care, family-oriented care, family health and family nursing, in combination with paediatric care/nursing in the languages English, Danish, Swedish and Norwegian. When possible, the keywords were extracted from the databases’ thesaurus index such as Mesh terms and CINAHL headings and only references containing the keywords as main terms were included. Subsequently, a search for the words ‘family cent*red care’ in the title or abstract was performed.

As the purpose was to produce a sample on the application of the concept in nursing research, limiters were set to reflect a rather narrow definition of scientific literature including only peer-reviewed research reports with an available abstract. Research was defined as empirical studies and theoretical reports based on a systematic review and only reports with the term family-centred care in the title or abstract were included to ensure a high degree of subject specificity. This specificity resulted in a data set of 68 references from which 25 were selected to form the material for the analysis. The final selection constituted a purposive sampling, in which different dimensions such as time, geographical origin, methods and perspective were explored. The criterion for inclusion was to retrieve the references that according to Morse (2000, p.350) are ‘theoretically rich’. This inclusion criterion meant that references containing definitions, characteristics, indicators or theoretical discussions about the nature of the concept were included whereas references with no clear implicit or explicit surmises were excluded.

Sample characteristics

Our sample subsequently consisted of 25 studies from 1990 to 2009 although almost 75% were published between 2000 and 2009. They predominately (22) originated from developed English-speaking countries (Great Britain, Ireland, USA, Canada, Australia) and the rest (3) are from Scandinavia. References from other European countries were found neither in the sample nor in the excluded references.

The sample consisted of two groups: various theoretical analyses (5) and empirical research with a descriptive design (20) (Table 3). Their methods varied, but according to Morse (2000), a concept analysis explores the researcher’s application of and assumptions about the concept, not the specific results of the research facilitating an integration of different research types.

Data analysis

Statements were identified and organized according to Morse et al. (2002) to reveal what Morse terms the anatomy understood as the current understanding of a concept. These were attributes, recognized as characteristics that are present in all contexts, where the concept occurs. Boundaries are
Table 3 Studies included in the sample

<table>
<thead>
<tr>
<th>Questionnaire</th>
<th>Interview</th>
<th>Observational/ethnographic</th>
<th>Method study (mixed)</th>
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<tbody>
<tr>
<td></td>
<td>MacKean et al. (2005)</td>
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<td></td>
<td>O’Haire and Blackford (2005)</td>
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<td></td>
<td>Palladellis et al. (2005)</td>
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<table>
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<th>Theoretical studies</th>
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<td>Systematic review</td>
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<tr>
<td>Shields et al. (2006)</td>
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<td>Shields et al. (2007)</td>
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features that permit a differentiation between concepts and allow one to determine, whether a concept can be applied to a certain phenomenon or situation. Preconditions render it possible to define the context, in which the concept occurs and lastly outcomes as the consequences, which follow the application of the concept.

Data from each reference were recorded and the statements subsequently organized into general themes, condensing the current understanding of the concept. The articles were reread and themes were compared to the original data to ensure faithfulness. Consensus was reached during team meetings, where findings were critically examined and questioned.

After identifying the current understanding of the concept, a principle-based analysis as operationalized by Penrod and Hupcey (2005), was conducted to form the basis of an evaluation of the degree of maturity.

We then searched for descriptions of how to use and understand FCC in the research process, in all statements concerning definitions, methods and instruments. We also explored how the concept fitted into a scientific context, i.e. related to other concepts and theories and in a clinical context, i.e. its ability to describe phenomena.

Results

To illustrate the current understanding of FCC, we constructed a diagram of the anatomy of the concept family-centred care (Figure 1) that suggested correlations between the features.

Attributes

Figure 1 illustrates how the central attribute of FCC was identified as a [partnership] that shares a core value of mutuality and common goals. The core value mutuality was e.g. defined by Hall as: 'to care and be open, to want to be of help for each other, to need and accept help from each other and to treat each other with dignity' (Hall 2007, p. 77). Thus, the value of mutuality implies that the needs of both parts should be considered and both should assume responsibility for a successful outcome.

Partnership encompasses the idea of a relationship between parents and professionals. The defining characteristics of this relationship were identified as the four themes: shared responsibility, parent autonomy and control, negotiation and family support.

The sharing of responsibility includes information, decision-making and caretaking. Having access to all information from the professionals and being recognized as an important source of information about the child, enables parents to take part in decision-making and caretaking as active members of the team (Hurst 2001, Holm et al. 2003, Weis 2006). In Evans’s (1994) study, the sharing of caretaking implies parents’ participation in traditional nursing tasks such as i/v medication whereas Harbaugh et al. (2004) explores the importance of nurses taking part in the non-technical aspects of care in the family system.

According to the theme parent autonomy and control, the goal of FCC is for the parents to become experts and assume responsibility for their child’s care and the professionals.

In order to define roles and responsibilities in the collaboration, negotiation on the child’s care and on who should give it is considered essential in several studies (Valentine 1998, MacKean et al. 2005, O’Haire & Blackford 2005, Corlett & Twycross 2006, Hughes 2007) and some studies point out the importance of allowing the parents to choose their degree of involvement (Espezel & Canam 2003, MacKean et al. 2005, Dix et al. 2009).

The final theme emphasizes the importance of family support. For example, Shields and Tanner (2004) stress the need for emotional support, recognized as the nurse’s sensitivity towards the parents’ individual needs and efforts to get to know the family.

Support of the parental role as the prime caregiver is in some studies considered as equally important. This support implies recognizing the fundamental need to defend and protect one’s child. Allowing parents to advocate for the child’s best interest is seen as facilitating their sense of control (Hurst 2001, Holm et al. 2003).

**Boundaries**

The strongest boundary identified constitutes a distinction between FCC and what is conceptualized as professionally-centred or medical models of care. These concepts cover caring, in which nurses are regarded as the experts who determine the family’s needs and make decisions in the best interests of the family. This concept is seen as a contrast to FCC because parents are offered a passive role, in which they are dependent on the nurse controlling the nature and extent of participation (Brown & Ritchie 1990, Bruce & Ritchie 1997, MacKean et al. 2005, Shields et al. 2007).

If parents try to obtain a more active role, conflicts about power and control may arise (Corlett & Twycross 2006, Hall 2007, Lundqvist & Nilstun 2007). Some studies state that the nurse’s actions may consciously or subconsciously take the form of gate-keeping, in which she will regulate the parent’s possibilities of participating (Valentine 1998, Corlett & Twycross 2006). However, Palladelis et al. (2005) points out that adhering to this model of care does not preclude the nurse from working with some of the principles of FCC and she may herself perceive her care to be family-centred.

The boundary of FCC is also defined by the presence of hidden expectations or unclear responsibilities (Valentine 1998, O’Haire & Blackford 2005). O’Haire and Blackford argue that parents, who behave adversely to the nurses’ expectations, may be at risk of being labelled as difficult and the nurses may refrain from communicating with them to avoid conflicts. Lack of communication may, according to Hall (2007), create insecurity, isolation and mistrust of the professionals.

**Preconditions**

The preconditions of FCC are described as both structural conditions such as organizational or educational needs and as conditions required for a partnership between the family and the professionals to develop. In the diagram, they are illustrated as the themes: nursing competencies, accept of mutual dependency and willingness to share responsibility.
The nursing competencies required to practice FCC are described as a theoretical knowledge of FCC and family dynamics, and possessing relational competencies such as communication, conflict management and a caring attitude (Valentine 1998, Harbaugh et al. 2004, Corlett & Twycross 2006, Hall 2007).

According to Lundqvist and Nilstun (2007), the collaborative relationship is characterized by the presence of dependency. FCC occurs as the consequence of a situation, in which the parents are dependent on the knowledge and expertise of the professionals, and the professionals are dependent on the child's emotional and physical attachment to the parents.

Several authors address the power relation implied in the presence of dependency. They suggest that for the collaboration to work, both parties must be able to accept the power relation and recognize each other's expertise. The shared responsibility for the well-being of the child means that parents may have to relinquish their exclusive role as caregivers, and likewise, nurses should be willing to share the decisions about nursing care (Evans 1994, Bruce & Ritchie 1997, Espezel & Canam 2003, Harbaugh et al. 2004, Weis 2006).

Outcome

The diagram presents both the positive and negative consequences of FCC. The majority of the studies consider a successful partnership as having positive consequences for both families and professionals. The overall outcome found in most studies is maintaining or strengthening the family's health, function and integrity (Galvin et al. 2000, Franck & Callery 2004, Weis 2006, Hall 2007).

To achieve this outcome, a major theme is supporting the normal parental role. The outcome of such actions is often described through the concept of empowerment. Weis (2006) defines empowerment as both strengthening the individual's own powers and resources and as countering oppressive forces, which may lead to powerlessness. She therefore sees empowerment as a goal of FCC as well as a strategy and a process. Several studies describe this goal as closely linked to the development of parental competencies through active participation in care (Evans 1994, Hall 2007). Another study explores the loss of dignity associated with the sense of powerlessness and therefore accentuates preservation of dignity as an essential goal of FCC (Lundqvist & Nilstun 2007).

For nurses, the positive consequences include increased opportunities to give individualized and coherent care, in which communication is improved and conflicts reduced, resulting in increased job satisfaction (Petersen et al. 2004).

Fewer studies address the potential negative outcome of FCC. For parents, the ideal of control and autonomy may have negative consequences. According to Hurst (2001) their sense of responsibility may lead to the understanding that they must be constantly vigilant. MacKean et al. (2005) argues that some parents feel they are expected to assume most of the responsibility for their child's care. Both cases may result in stress and increased encumbrance. Furthermore, Shields et al. (2006) argue that the expectation of parents being ever present and participating can be an economical burden and affect the emotional and social balance in the family for e.g. in relation to siblings.

To nurses, the blurring of roles may be seen as a threat to their professional identity (Bruce & Ritchie 1997). This identity-threat is considered stressful and may lead to actions with the unconscious purpose of regaining control. However, O'Haire and Blackford (2005) underline that this identity-threat is not only a question of power relations, but also of professional responsibility. If parents and nurses do not agree about the child's care, the nurse may feel a moral dilemma.

Maturity of the concept of FCC

The following principle-based analysis incorporates the established anatomy of FCC and a second review of the analysed texts in the evaluation of maturity.

Evaluation of the concept's clarity and differentiation from other concepts

In the analysis, no single, consistent definition of FCC was identified; instead the studies referred to FCC as a set of principles or a philosophy. These principles were frequently attributed to the work of Shelton et al. (1987).

Four different definitions were being used, reflecting different perspectives on FCC. Table 4 demonstrates the differences on a continuum going from an emphasizing of the autonomy and equality of the family in relation to the professionals to a view of the family as potential care recipient without explicitly addressing its active, participating role.

Our findings indicate a strong association to the concepts of partnership, parental involvement and parental participation. As the terms are used interchangeably in the included studies, they seem to be competing or surrogate terms. There is good agreement on the constitution of the defining attributes of FCC. The preconditions, boundaries and outcome in the majority of the studies were, however, not clearly stated but were implicitly inferred.
Table 4 Definitions of FCC

<table>
<thead>
<tr>
<th>Source</th>
<th>Definition</th>
<th>Diagram</th>
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<tbody>
<tr>
<td>Bruce and Ritchie (1997)</td>
<td>'A philosophy of care that recognizes and respects the pivotal role of the family in the lives of children with special health needs. It is a philosophy that strives to support families in their natural caregiving roles by building upon their unique strengths as individuals and as families. It is a philosophy that views parents and professionals as equal in a partnership committed to excellence at all levels of health care'</td>
<td></td>
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<tr>
<td>Carmen et al. (2008)</td>
<td>'An approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families. PFCC recognizes the integral role of the family in the health and wellbeing of the patient. It applies to patients of all ages and may be practiced in any healthcare setting'</td>
<td></td>
</tr>
<tr>
<td>Lambert et al. (2008)</td>
<td>'The professional support of the child and the family through a process of involvement, participation, and partnership underpinned by empowerment and negotiation'</td>
<td></td>
</tr>
<tr>
<td>Shields et al. (2006)</td>
<td>'Family centred care is a way of caring for children and their families within health services which ensures that care is planned around the whole family, not just the individual child/person, and in which all the family members are recognized as care recipients'</td>
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Evaluation of the concept's applicability and usefulness to the discipline

The majority of the included empirical studies explore differences in healthcare professionals' perceptions and practices of FCC. Three different quantitative instruments are identified, in which participants rate the perceived presence of a number of criteria for FCC on a Likert scale (Galvin et al. 2000, Shields & Tanner 2004, Dix et al. 2009). This operationalization of the concept enables the studying of nurses' and families' perceptions of FCC and their opinions on its presence in the clinical setting but does not empirically detect its presence by the use of directly observable data. Such an instrument is presented by Carmen et al. (2008). The purpose is to facilitate the organizational assessment and implementation of FCC and to perform benchmarking between institutions.

In a more research-oriented attempt to operationalize the concept, Franck and Callery (2004) address the lack of empirical indicators. Based on a literature review, they offer a model linking the abstract constructs of the conceptual system to an operational system with observable empirical indicators, constructed to act as measurable outcome variables in different kinds of interventional studies.

Evaluation of consistent and appropriate use of the concept in context

In two studies the usefulness of elements in the concept is tested in a clinical setting. The elements explored are empowerment (Weis 2006) and parental participation (Evans 1994) – both of which are central characteristics of the anatomy of FCC as presented in the diagram.

There is some confusion concerning the level of abstraction of the term FCC, as it is described as a philosophy and a model of care. There is, however, agreement that it is generally accepted in children's nursing. Citations are made to the same historical references although some emphasize the connection to the consumer and patient rights movement (Galvin et al. 2000, Petersen et al. 2004) whereas others underline more pragmatic realities – parents are needed because of the shortage of nursing staff (Evans 1994).

The identified definitions of FCC express two views of parents as both care providers and care recipients. This view may be because the definitions are construed from different perspectives respectively, from a consumer and a provider of healthcare perspective. It may also indicate that applying a concept to a hospital context makes a redefinition necessary.
Shields and Tanner (2004) argue that two distinct groups of children and families exist in the healthcare system. One consists of children with long-term or enduring illnesses who are cared for at home and receive various healthcare services and the other of children facing acute, short-term admissions to hospital. These are two very diverse contexts and the scope of the concept may not be able to fit both.

Not all empiric studies state the precise population in terms of clinical setting or clinical condition, but several include more than one setting in the same hospital. The most common contexts explored are neonatology and oncology, a shared characteristic here being a relatively long hospital stay.

Despite an attempt to define the term ‘family’ broadly to include a range of different social relations (Franck & Callery 2004, Shields et al. 2007), the informants used in studies exploring the perspective of families mainly consist of mothers (approx. 80%). This indicates that the current scientific use of the concept FCC builds on a narrow understanding of the term ‘family’ primarily constituting knowledge of the mother’s views. Only one study (Lambert et al. 2008) uses children as informants, exploring their experiences of one of the central elements of FCC namely communication.

The concept’s boundaries when integrated with other concepts

There are several concepts related to FCC such as parent participation, parent involvement and partnership and no clear differentiations have been identified. However, due to the narrowing of the literature search, these concepts were not explored or compared in the present analysis.

What does stand out is that FCC is a very high-level, abstract concept encompassing a number of underlying concepts, which have varying levels of abstraction and are not all clearly positioned in the theoretical scheme.

In our diagram of FCC, support is an example of a high-level concept with a broad application, which may include other underlying concepts. Stress and empowerment are more specialized mid-level concepts that are applied to a particular phenomenon whereas negotiation is a low-level concept referring to a particular set of behaviours and thus has a narrow application.

Morse has suggested the term paradigmatic to characterize a concept as abstract as FCC. This describes ‘scientific concepts of a very high-level of abstraction that are applied deductively to a cluster of concepts or a developing theory’ (Morse 2004, p. 1393).

However, only two studies attempt to integrate FCC into a theoretical framework. Both refer to family-systems theory, which Harbaugh et al. defines as ‘a theoretical model that explicates family structure and functioning in and outside the family. This includes relationships across its boundaries with other systems, including the healthcare system’ (Harbaugh et al. 2004, p. 164). Hall (2007) likewise applies the family-systems theory in her dissertation about the dynamics in the family-professional systems.

Definition of FCC

When comparing the findings depicted in our diagram of FCC to the existing definitions (Figure 1), it turns out that the definition from Lambert contains several of the elements found in our analysis. Our analysis adds the importance of shared responsibility and the mutual dependency embedded in the relationship. We therefore propose the following:

‘FCC is the professional support of the child and the family through a process of involvement and participation, underpinned by empowerment and negotiation. FCC is characterized by a relationship between healthcare professionals and the family, in which both parts engage in sharing the responsibility for the child’s health care’.

Discussion

The limitations to this study predominately relate to the narrowing of the literature search, resulting in a relatively small data sample. This limits the applicability of the findings to the context of FCC to children in hospital as represented by the clinical settings included in the sample. However, our findings support previous analyses (Hutchfield 1999, Malusky 2005).

Due to the elected scope of the literature search, in which only the term FCC was included, related or surrogate terms have not been explored. This affects the findings concerning the boundaries of FCC and the relationship between the concepts of involvement, participation and partnership.

The decision to define scientific literature as research articles resulted in a sample of relatively new material with the majority from 2000 and later on. Therefore, any development of the concept over time could not be analysed. Nevertheless, the similarity of our findings and the earlier analyses indicates only small changes in the concept over time.

Our analysis and diagram of FCC reflects the current application related to the analysed data. However, it also highlights areas of inadequacies that need to be addressed in order to develop the concept. Some of these points will be discussed below.

The evaluation of the maturity of FCC reveals a concept, which is only partially mature. The concept holds
Shields and Tanner (2004) argue that two distinct groups of children and families exist in the healthcare system. One consists of children with long-term or enduring illnesses who are cared for at home and receive various healthcare services and the other of children facing acute, short-term admissions to hospital. These are two very diverse contexts and the scope of the concept may not be able to fit both.

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The evaluation of the maturity of FCC reveals a concept, which is only partially mature. The concept holds
What is already known about this topic

- The term family-centred care is commonly used in children's nursing, but has no clear definition.
- Difficulties in implementing family-centred care in practice have been repeatedly identified, suggesting a theory-practice gap.
- Research has failed to show the effectiveness of the family-centred method as a model of care.

What this paper adds

- There is good agreement on the defining attributes of the concept, but they are described by subconcepts, which need to be clarified and related.
- The concept is defined from the perspective of professionals and families, mainly represented by mothers, rather than that of the sick child.
- The sharing of responsibility for the child's care holds potential areas of conflict, which are not fully explained by the attribute of partnership.

Implications for practice and/or policy

- Developing a theory of FCC would help facilitate the concept's progression to a more mature level.
- A relationship between families and professionals is an essential prerequisite for FCC to occur and a deeper understanding of the mutuality of this relationship is needed.

subconcepts on various levels of abstraction, many of which need further clarification. Paley discusses the value of such findings: 'in the interest of conceptual clarification, defining attributes can make use of terms, which are as much in need of clarification as the term they are said to define' (Paley 1996, p. 576). This underlines the need to further clarify and define the sub concepts and their interrelatedness.

Some authors (Hutchfield 1999, Hall 2007) have suggested that developing a theory of FCC would render the concept more useful to the nursing profession because of a theory's ability to explain phenomena and relationships and guide practice and research. This, we agree, would be a possibility to advance the concept to a more mature level as it may help integrating and explaining the mutual relations of the underlying concepts.

Both Harbaugh et al. (2004) and Hall (2007) apply the family system theory to their studies on FCC and Nethercott (1993) argues that FCC has a theoretical association to a systems theory framework, which our analysis supports. We consider this framework to have the potential to elucidate the impact of illness on the role of family members and the interaction between the family system and the professional system.

Another finding in our analysis, suggesting that the concept is only partially mature, concerns its fit with the phenomenon it describes. Some studies explain a discrepancy between nurses' perceptions of FCC and their practice as a theory-practice gap. We suggest instead that this discrepancy points to a possible inherent antagonism in the current scientific understanding, requiring an investigation into the fit of the concept. Seeing FCC as a paradigmatic concept provides an explanation as this type of concept holds no direct link to data but is placed deductively to an emergent theoretical scheme (Morse 2004). This may explain why only isolated elements in the concept were tested clinically and not FCC in its entirety.

An example from our analysis is the frequent use of the term partnership to describe the nurse-parent relationship although it has not been supported empirically. Coyne and Cowley's research on partnership provides the same conclusion arguing that this concept may be inappropriate and does not reflect the current experiences of families and nurses in hospital (Coyne & Cowley 2007). As pointed out by Paley, the use of such a concept as a defining attribute does not clarify the meaning of FCC, which is why we have left it out of the integrated definition and the diagram.

Based on our findings, one problem concerning the fit of this term seems to be its lack of ability to explain the conflict between professional autonomy and the autonomy of the parents revolving around the responsibility for the child's care. It may therefore be, as also discussed by MacKean et al. (2005), a mistake to conceptualize FCC as training parents to take over this responsibility. Rather, an understanding of FCC should be explored, in which the essence instead of autonomy and control is the mutuality of working together. Hall (2007), whose theory of family-professional dynamics contains mutuality as one of four key elements, presents one such perspective.

The perspective of the ill child is not very prominent in the current conceptualization of FCC: only one study chooses to explore this perspective. As a consequence, the outcome of FCC is described mainly through the advantages/disadvantages to parents and nurses. As others also mention (Franck & Callery 2004), it is a mistake to assume that the objectives of the child and the parents are always the same and thus it is important that the health of the child is given a pivotal place in a theory of FCC.
Conclusion

Our theoretical analysis of FCC for children in hospitals as used in a research process presents a concept, which is only partially mature. Different definitions are being used and the theoretical context seems weak without sufficient explanation of the relations of the features. Operationalization in the form of measurable indicators of FCC is being attempted in various research contexts but as yet with no consistency in use.

We therefore suggest developing the concept into a theory of FCC, which includes the perspectives of families and nurses and is applicable in different clinical contexts. Our analysis reveals a concept, in which the term family addresses mostly mothers, excluding not only fathers, siblings and other relatives but also assuming that the interests of the ill child always equals that of the parents. This inference suggests that seeing the family as a unit carries the risk of overlooking the needs of some members. When exploring the perspectives of families, it would therefore be advantageous for future research to focus on additional family members, especially the role of the ill child in order to broaden the understanding of the concept.

More knowledge is needed on how to incorporate the notion of partnership into a developing theory of FCC. This would require research into the complicated social relations affected by the attitudes and behaviour of family members and nurses and into the potential consequences for both parts.

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Author contributions

GM was responsible for the study conception and design. GM performed the data collection. GM performed the data analysis. GM and KF were responsible for the drafting of the manuscript. GM and KF made critical revisions to the paper for important intellectual content. KF supervised the study.

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