

ORIGINAL RESEARCH

OBSTETRIC ANESTHESIA

The perception of obstetric healthcare workers to the partners' presence in the operating room-a phenomenological study

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ABSTRACT

Objective: It is current practice in our setting to not admit a partner in theatre during cesarean section (CS) even though this is becoming commonplace in various countries. This study is designed to determine the views of healthcare workers, postpartum mothers and their accompanying partners on having a partner present in the operating room (OR) during an elective CS at Port of Spain General Hospital, Trinidad, West Indies.

Materials and Methods: The study's theoretical model was based on a constructionist, interpretivist framework as well as phenomenological research. A semi-structured interview was conducted and a thematic approach was used to develop codes. This was analyzed by Qualitative Data Analysis (QDA miner) software and the following themes emerged: 'Maternal support'; 'Fathers' marginalization'; 'Nurses' perception of fathers' role'; 'Healthcare workers' perception of litigation and 'Limiting factors'.

Results: 70% of respondents were in favor of a partner being present in the operating room for an elective CS and thought it would help to keep the mother at ease by allowing her to hold hands with the partner, talk to them and be accompanied by them to the recovery room. Healthcare workers did think that male partners might not have much of an impact in the operating room as they would not know what to do and may actually pose a security threat if things did not go exactly as planned.

Conclusions: Healthcare professionals were neutral about partners being present in the operating room but had concerns regarding partner's presence in the operating room.

Key words: Anesthesia; Cesarean section; Health personnel; Parturients; Obstetric; Perception

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1. INTRODUCTION

Parturients have been reported to be more depressed if they have to undergo cesarean section (CS), than the women who have to deliver vaginally.¹ Feelings of guilt, anger, envy of other mothers, and resentment toward their babies are common reactions from mothers having cesarean deliveries.² Assistance and reassurance from their life partner can alleviate some of their psychological burden. At some centers, if partners have

attended few birth classes, they are allowed to be in the labor room for a vaginal delivery. This is not the case for most of the parturients undergoing elective CS. Fathers and partners are often shunned from the maternity ward, but a study done by Ribeiro et al. investigated the fathers'/partners' perception of their presence in the labor process and found that most of the fathers acknowledged that the accompanying of their female partners in labor was a positive experience, since they were able to contribute towards support, confidence, comfort and physical and emotional well-being.³ Fathers

also felt good about their own presence during labor and negative when they were absent.⁴ Fathers' presence offers a welcome possibility of early bonding with the new born, as otherwise their usual point of contact will be with the baby in the incubator. Fegran et al. thought the first instance of intimate contact between a father and his child creates self-awareness for the former—who is a key provider for the new born—and may further catalyze feelings of affinity and protectiveness.⁵ One study outside of the Caribbean found that many still oppose the idea of a partner being present, arguing that the 'invited guest' often finds the experience emotionally painful, even traumatic, that they can interfere with the staff's work and decision making, and that their close attendance might even multiply already frequent enough malpractice claims.⁶ CS was considered as a routine and safe procedure that offered most fathers a sense of certainty, control and safety lessening their sense of responsibility over ensuring a healthy baby. The communication patterns of staff played a key role in ensuring a positive cesarean birth experience.⁷ There is very little research data on this topic and little to none was found in a Caribbean population. With this study we hope to change the current trend into a positive one.

2. METHODOLOGY

This study takes into account a theoretical basis which would emphasize a constructionist (philosophy), interpretivist (theoretical perspective) framework in addition to phenomenological research (methodology) aided by a questionnaire and semi-structured interviews, using a phenomenological method to aid in the analysis.

The study was conducted at the Port of Spain General Hospital in Trinidad and Tobago. It was a convenient sampling technique, comprising all obstetricians, all anesthetists, all labor nurses, all OR nurses in the maternity department, mothers in the immediate puerperium, aged over 18, who had the father of their baby/partner present throughout the labor, and who were or were not present during the elective CS. After the identification of the eligible participants, a questionnaire was distributed via an e-form in keeping with COVID protocols in November 2021. It was then followed by interviews in December 2021. The interviews were undertaken in groups: 1. anesthetists and maternity room nurses, 2. obstetricians and labor/delivery nurses and 3. postpartum mothers and their partners. The sample size was determined using a paper published which found that semi-structured/in-depth interviews require a minimum sample size of 5–25.¹⁰ The interviews lasted a maximum of one hour and they were conducted one after another on the same day.

University of The West Indies ethics approval was obtained. Virtual semi-structured interviews were set up

with thirty-two persons from December 2021 to February 2022, they were randomly contacted by the chief investigator (CI). The interview groups consisted of the following;

- a. Anesthetist and operating room staff = 10
- b. Obstetricians and midwives = 8, and
- c. Mothers and partners = 14.

The interviews were audio recorded in full after obtaining consent. All correspondence was virtual with no in-person contact.

3. RESULTS

3.1. THEMES GENERATED

3.1.1. Maternal support

Spousal willingness and mothers' choice of whom to accompany them in the cesarean room were the most significant reasons found for the need of spousal support. The presence of a familiar person like the father/partner enhanced the patient satisfaction. Mothers felt that their anxiety would be reduced having a partner/father present with them as they were not familiar with the doctors or nursing personnel. Both mothers and partners/fathers thought it should be the mothers' choice who accompanies them during the surgery; although most of them thought that the partners/fathers played no role in this setting. Some nurses who worked both in public as well as private sector medical institutions, even mentioned they never witnessed a partner/father in the public sector operating room. *"I've never seen a partner in the operating room in public, certainly private setting all the time."*

3.1.2. Fathers' marginalization

The interview segment contained ten fathers/partners, who mostly felt that their main role was for spousal support and they also thought that their presence was important for bonding with the baby, quite similar to the baby being placed on their mother's chest post-birth. This fosters a positive and nurturing connection between fathers or partners. New fathers have been shown not only to develop close emotional ties with their child three days postpartum, but also to invest and sustain a strong interest in him or her during this period.^{12, 13} Consequently, skin-to-skin contact may help decrease parental anxiety and enhance the dependency relationship. More frequent interaction with the infant may indicate that a father is providing increased levels of positive parenting behavior as measured by the five facets: sensory stimulation, physical care, warmth, nurturing, and 'fathering'.^{9, 10, 13} According to Mau and Huang (2010), the father plays a pivotal role in terms of

family functionality, childhood development, and child well-being.¹⁴ Children with positive father-child relationships may develop models of caregivers as trustworthy and supportive and later approach others with positive attitudes and expectations.

3.1.3. Nurses' perception of fathers' role

The group of nurses, comprising both OR nurses and labor ward nurses/midwives, was interviewed and the above theme was generated from their responses. They did not think that fathers/partners played much of a role in this setting traditionally and these sentiments were echoed by the fathers/partners. One of the nurses commented that *"It's a degree of tradition, I think that is just not the way things have been done properly, and it has remained like that, but in my experience it's just traditional."*

Another nurse focused on the lack of patient education, resulting in them being unprepared for the OR environment. A word count of 79.5% held this opinion: *"Well, I think in my opinion the risk would be if they are unprepared, or they don't have good patient education. They might even be scared for what's going on because when you speak to patients or relatives on the ward, they're worried everyone will die if they don't have blood; our perception of blood loss is a lot more lenient than their perception of blood loss"*.

Most men felt that the environment was not a man's place and the nurses also weighed in on this thought. The statement by a nurse illustrates it; *"I know why I'm DOIng certain things than, say, a male partner who, well, this especially this is his first child, I don't know if that makes sense, so as in a woman who's gone through this before would know why I would be why we have to put up access and why I'd be giving sits in things over here in the conversation and she would. But if it would make me nervous as to whether it's a male or female, or if it's some other partner. I really don't think it would make a difference to me."* Only 0.9% of words went toward the thought of mothers mainly being held accountable for everything *"When it comes to rules around childbirth, mostly mothers do everything."*

3.1.4. Healthcare workers view on litigation

This was another strong theme discussed by all participants in the interview, because the implications are much stronger for health care workers, their view on litigation was given a closer look. One nurse expressed that it was not much of a concern for her *"Yeah, I'm not worried about the legal aspect, I think true in mind all the time some things happen in theatre and like we have to write our report afterwards and we pretty much do everything. Everything that we do is transparent, I'm not concerned about that aspect."* Another nurse thought

differently, *"I don't know, for legal purposes, I guess. Sometimes the most routine of cesarean sections could go south."* Doctors thought it would be a disadvantage if partners/fathers were around to see all that was taking place *"That is also a disadvantage that in case anything went wrong, you were present to see it."*

This theme was stronger in nurses as compared to doctors. Patient satisfaction was also mentioned by the doctors *"I think that also patient satisfaction is a problem in public versus private sector, whereas with private they are more patient and nothing that we are not considering patient satisfaction but they their very livelihoods depend on it. If we get one bad review, we will still continue whereas in private if you get one bad review, it can significantly affect your business. It speaks a lot and therefore they go the extra mile like having a partner in the anesthetic room itself as opposed to us because they are concerned with patient satisfaction, I think."*

4. DISCUSSION

The aim of this study was to determine the views of healthcare workers along with peripartum mothers and their respective partners toward having a partner present in the operating room for an elective CS, in the public setting. In the US a mandate had been made since 1981, encouraging hospitals to liberate their policies on the ability to have a father or partner present for a CS.¹⁵ However, this policy has not been accepted by the public hospitals of Trinidad and Tobago. The UK was also found to have this option available for partners and fathers, mostly when surgery is performed under a spinal anesthetic.¹⁶

The interview generated the following themes: maternal support, father's marginalization, nurses' perception of father's role, healthcare workers view on litigation and limiting factors. Several studies have demonstrated that providing this emotional support by the partner may help to alleviate stress and fears, promote strength, endurance, comfort and security, and help distract from the pain.¹⁷ and this was echoed by the mothers present in our interview. The participant in one study explained, *"I think having a supportive partner, my husband, and faith in God, that this was meant to be for some reason; it helped me to accept having a cesarean delivery"*.¹⁸ Mothers felt that support was needed during this time even if it were to have someone who would be responsible for remembering all the extra information that would be usually given about the postpartum period. This is due to them being tired and possibly in pain post CS. In the study by Cain et al. it was concluded *"the husband should be present for the delivery if the couple desires, and that this is a factor contributing to an*

enhanced positive birth experience and a normal post-delivery course of resolution.⁴

Digging deeper into father's marginalization revealed that society and healthcare workers alike felt that it was not a man's place and traditionally no one really expects the father to be present during this time. Some of the comments by respondents included: "I think the reasons why they might have been excluded as I say would be our cultural things", "It's not something you would have heard a lot of guys or society really talk about before in terms of the benefit for the father being around right". The fathers however disagreed with the sentiments expressed. Ribeiro et al. investigated the perception of the fathers in the labor process and similar sentiments were echoed as those in the current study, one father described his experience: "It was the first time I was accompanying her all the time until the delivery ended ... my presence was very necessary because I gave her more strength and confidence because everything is not easy for the woman ... I see the accompaniment in a positive way because it is the responsibility of both and not to play the responsibility only on the mother's back".³ Some fathers also mentioned that due to knowing the mother of their child very well, they may not want to be present in the operating room and thought it was best that someone else be present. Not all fathers are ready or willing to be present for a cesarean delivery, as is still true for vaginal births.¹⁹ "I find the cesarean kind of strange. I helped during the normal birth, I held her leg, I even cut the babies' umbilical cords; but in the CS I wouldn't be able to help with anything, so it was good, you know, everything went right. I think it was better not to have seen her stomach all open".⁸ Even though healthcare workers identified the positive aspects of partner presence, they did still feel that they might get in the way, one obstetrician said, "I agree that the infrastructure is a large component, limiting the partner's presence."

One of the nurses said, "You have someone who could support their partner and even reduce the patient's anxiety". Cox et al. agreed that nurses could give the father the support, so that he in turn will support his wife. Involve him as much as possible, encouraging his participation. If the couple has attended a class for childbirth preparation, continue the teamwork philosophy as much as possible.² They felt that it was a family unit and not all the responsibility should fall squarely on the mothers' shoulders. In addition to this they did think it would help in the bonding process, where they themselves would be able to connect to the baby when born. The participants of this study also agreed that partner presence would aid in bonding, one anesthetist said "I was thinking that you would have the entire family and being able to bond a lot earlier in the process". In the study by Chen et al. this was also found,

the first instance of intimate contact between a father and his child creates self-awareness for the former—who is a key provider for the new born—and may further catalyze feelings of affinity and protectiveness. They did, however, think that they should tour the operating room first or attend classes.²⁰ They advocated to assist and encourage local hospitals to develop programs that allow father's presence at cesarean birth. Bridge the gap with the hospital. Encourage a tour of the hospital, and encourage voicing preferences and concerns with nursing staff.²

Our study had one doctor say, "the only way that the partner gets to attend is, if they attend the antenatal class. I think to attend the CS or even the emergency CS, should also be a prerequisite so that the relative wouldn't be surprised and they would at least know what to expect". The main conclusion drawn by Lipson et al. was that delivery and operating-room staff need to be trained in the skills needed to promote the active participation of the baby's father in delivery and, if necessary, in a CS.¹ Even though the literature of some studies held healthcare workers as the cause for partner absence in the OR, this study showed that that was not the case. Almeida et al. found that partner absence evidenced the negative feelings regarding the experience; the woman felt unsupported due to the absence of her companion, and the companion felt disappointed because of not experiencing the birth of their child. The main factor behind this separation was the attitude of the health professionals, who continue to impede the companion's presence in the OR.⁸

Figure 1: A word cloud representing overall perception of a Father's role as a birthing partner during cesarean section.



Litigation was also a strong theme mentioned in the interview portion of the research. One nurse did not seem phased by it as they ensured to keep checks and balances on what they do intraoperatively. Doctors, however, felt that it would be a disadvantage having that extra person around to witness everything that took place. One patient even admitted that her partner was intentionally observing the operation looking for any wrongdoing, to report it higher up. Gutman et al. found that many still oppose the idea of partner presence due to the 'invited guest' interfering with staff's work and decision making as well as increasing the probability of malpractice claims.⁶ The healthcare workers in this study thought that due to the current infrastructure, it may not be feasible having an extra person inside OR. They also made reference to a private hospital being equipped with more space and privacy for mother and her partner. They felt that if an emergency were to occur, and they had to move quickly, it might be difficult to maneuver with the partner being present. Gutman et al. also thought that an anesthetist's work is extremely intense and critical, and this too may cause them not to welcome 'guests', all the more so as the place usually assigned to these guests in an OR is the area which the anesthetist is responsible for.⁶

5. CONCLUSION

The presence of the father of the unborn baby during cesarean delivery has been accepted as a normal routine in many of the developed countries. Various studies have shown its advantages, in terms of increased bonding between the family, reassurance and sense of protection to the parturient and a renewed commitment by the father towards the newborn and the mother. Yet in many of the developing countries, this custom has met negative speculation, and the opinions among the healthcare workers remain divided. Family participation in the coaching classes in the obstetric department might be helpful to remove the taboos in the concerned parties.

6. Data availability

The data generated during the conduct of this study is available with the authors.

7. Conflict of interest

The authors declare no conflicts of interest. No funding, external or industry, was involved in the research.

8. Statement of Ethics

After ethical approval was granted by the Ethics Committee (No. Ref: CREC-SA.1135/08/2021), questionnaires were distributed virtually to all obstetric physicians (consultants, registrars and senior house officers), all Anesthetic physicians as well as all theatre and midwifery nursing staff. Mothers and

their accompanying partners were recruited on the obstetric ward at the Port-of-Spain General Hospital.

Preliminary consent was obtained after acquiring telephone numbers and secondary consent was obtained after mothers and their accompanying partners agreed to take part in the study. From this a WhatsApp group was generated, and information on consent and aim of the study was discussed.

9. Author Contributions

DV: Manuscript design, Interviews, final editing

KG: Conceptualizing, collection of data, initial write up.

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ANNEX-A: QUESTIONNAIRE

Research Title: View of partners in the Caesarean room: Should it be allowed and why doesn't it occur in the public setting? A Caribbean Perspective.

There are no risks or hazards associated with this study.

The study would be conducted over a period of four months (December 1st 2021 to April 1st 2022)

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Agreement is entirely voluntary.

The option to agree to participate or to decline is available.

State whether you are an obstetrician/anaesthetist/labor or delivery nurse/pregnant mother/partner (father or any other accompanying person)

1. How old are you?
2. Do you think that partners should be allowed in the theatre during Cesarean section?

If yes to question 2, please answer sections 1, 2 and 3.

If no to question 2, please omit section 1 and answer sections 2 and 3.

For each of the questions below, circle the response that best characterizes how you feel about the statement, where: 1 = Strongly Disagree, 2 = Disagree, 3 = Undecided, 4 = Agree, and 5 = Strongly Agree.

Section 1: Conditions for admission.					
Questions	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
The opportunity for partner to be in the OR. should be willingly offered	1	2	3	4	5
The opportunity for partner to be in the OR must be requested	1	2	3	4	5
A support person other than the partner should be allowed in the OR	1	2	3	4	5
Partner should not be allowed in the OR for a general anaesthetic	1	2	3	4	5
Partner can enter the OR if the type of anaesthetic used is a regional technique	1	2	3	4	5
It is appropriate to allow partner in the OR for elective cases	1	2	3	4	5
It is appropriate to allow partner in the OR for emergency cases	1	2	3	4	5

Partner should not be excluded from entering the OR even if mother has not received antepartum care at POSGH	1	2	3	4	5
Partners who are not present during mothers' antenatal care should still be allowed to accompany them in the OR	1	2	3	4	5
Mandatory educational sessions on childbirth via caesarean section should be compulsory prior to admittance to OR	1	2	3	4	5
Consent must be signed by partner outlining the risks of surgery before admission to OR	1	2	3	4	5

Section 2: Appropriate behavior for mother in the OR					
Questions	Strongly Disagree	Disagree	Undecided	Agree	Strongly Disagree
Mother can touch, hold or even breast feed her baby during surgery	1	2	3	4	5
Mother can be allowed to view the delivery with a mirror or by lowering anaesthesia screen	1	2	3	4	5
Mother's view should be obstructed with the anesthesia screen	1	2	3	4	5
Mother will be more anxious with partner present	1	2	3	4	5
Mother will be at ease with partner present	1	2	3	4	5
Communication between mother and partner can occur while surgery ongoing	1	2	3	4	5
Mother cannot hold hands/ be in close proximity with partner during surgery	1	2	3	4	5
If mother is uncooperative partner should no longer be allowed to enter the OR	1	2	3	4	5

Section 3: Appropriate behavior for partner in the OR					
Questions	Strongly Disagree	Disagree	Undecided	Strongly Agree	Agree
Partner entering the OR, before anesthesia should be encouraged	1	2	3	4	5
Partner should not sit in close proximity to anesthesia staff	1	2	3	4	5
Partner should be allowed to view the surgery and take pictures	1	2	3	4	5
Partner can hold the baby in the OR	1	2	3	4	5
Partner should not be asked to leave the OR if complications arise	1	2	3	4	5
Partner can accompany and stay with mother in the recovery room	1	2	3	4	5