



The impact of a father's presence during newborn resuscitation: a qualitative interview study with health care professionals

Journal:	<i>BMJ Open</i>
Manuscript ID:	bmjopen-2013-002547
Article Type:	Research
Date Submitted by the Author:	02-Jan-2013
Complete List of Authors:	Harvey, MerryI; Birmingham City University, Child Health Pattison, Helen; Aston University, Life Health Sciences
Primary Subject Heading:	Paediatrics
Secondary Subject Heading:	Qualitative research, Paediatrics, Obstetrics and gynaecology
Keywords:	NEONATOLOGY, Neonatal intensive & critical care < INTENSIVE & CRITICAL CARE, QUALITATIVE RESEARCH

SCHOLARONE™
Manuscripts

Peer Review Only

1
2
3 **The impact of a father's presence during newborn resuscitation: a qualitative**
4
5 **interview study with health care professionals**
6
7
8
9

10
11
12 Merryll E Harvey, Helen M Pattison
13

14
15
16
17
18 Merryll E Harvey senior academic Faculty of Health, Birmingham City University,
19
20 Birmingham B15 3TN Helen M Pattison professor School of Life Health Sciences,
21
22 Aston University B4 7ET
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53

54 Correspondence to: Dr Merryll E Harvey merryl.harvey@bcu.ac.uk
55
56
57
58
59
60

ARTICLE SUMMARY

Article Focus:

The research question for this study was; 'What are the experiences of health care professionals of the father's presence during newborn resuscitation in the delivery room?' To address this question, the objectives of this phase of the study were:

1. To conduct interviews utilising the critical incident approach with HCPs who had experience of newborn resuscitation when the baby's father was present.
2. To provide an account of the experiences of HCPs of newborn resuscitation when the baby's father was present.

Key messages:

The key messages and significance of the study are:

1. Whilst the health care professionals were aware of the information and support needs of fathers during newborn resuscitation, they acknowledged that these needs were rarely met.
2. The health care professionals in this study had not received education and training specifically about supporting fathers during newborn resuscitation.
3. The health care professionals in this study did not utilize strategies to support fathers that are recommended when relatives are present during resuscitation events in other critical care settings.

Strengths and limitations:

This independent study is the first reported exploration of the experiences and perceptions of health care professionals involved in neonatal resuscitation in the delivery room when the baby's father was also present. The critical incident approach proved to be an

1
2
3 appropriate way to gain insight to the participants' experiences and the context in which the
4
5 resuscitation occurred. Asking participants to focus on the father enabled many of them to
6
7 consider the impact of newborn resuscitation on fathers for the first time. Although some
8
9 participants chose to describe events that occurred a while ago, they had no difficulty
10
11 remembering what happened or their feelings at the time. Whilst some participants found
12
13 describing events upsetting; no-one wished to discontinue the interview. Although
14
15 undertaken in one setting, the extent to which the findings apply to other health care
16
17 professionals encountering newborn resuscitation can be considered.
18
19
20
21
22
23

24 **Abstract**

25
26 **Objective:** To explore the experiences of health care professionals of the father's
27
28 presence during newborn resuscitation in the delivery room.
29

30
31 **Design:** A descriptive, retrospective design using the critical incident approach.
32
33 Tape-recorded semi-structured interviews were undertaken with health care
34
35 professionals involved in newborn resuscitation. Participants recalled resuscitation
36
37 events when the baby's father was present. They described what happened and how
38
39 those present, including the father, responded. They also reflected upon the impact
40
41 of the resuscitation and the father's presence on themselves.
42
43

44
45 **Setting:** Participants were staff recruited from a large teaching hospital in the UK.

46
47 **Participants** A purposive sample of 37 health care professionals including midwives,
48
49 obstetricians, anaesthetists, neonatal nurse practitioners, neonatal nurses and
50
51 paediatricians.
52

53
54 **Results** Participant responses were analysed using thematic analysis. Four themes
55
56 were identified: 'whose role?' 'saying and doing' 'teamwork' and 'impact on me'.
57
58 Whilst no-one was delegated to support the father during the resuscitation, midwives
59
60

1
2
3 and anaesthetists most commonly took on this role. Most participants felt the midwife
4 was the most appropriate person support fathers. All health care professional groups
5
6 said they often did not know what to say to fathers during prolonged resuscitation.
7
8

9
10 Teamwork and inter-professional working were felt to be of benefit to all concerned,
11 including the father. Some paediatricians described their discomfort when fathers
12 came to the resuscitaire. None of the participants had received education and
13
14 training specifically on supporting fathers during newborn resuscitation.
15
16
17

18 **Conclusions** This is the first study to specifically explore the experiences of health
19 care professionals of the father's presence during newborn resuscitation. The
20
21 findings suggest the need for more focused training about supporting fathers. There
22
23 is also scope for service providers to consider ways in which fathers can be
24
25 supported more readily during newborn resuscitation.
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

INTRODUCTION

When a newborn baby requires resuscitation in UK settings, the father will usually be present because most fathers attend the birth of their baby and delivery and resuscitation generally take place in the same room (1,2,3). Whilst some studies have investigated the impact on health care professionals (HCPs) of parental presence during neonatal resuscitation in the neonatal unit (NNU) (4,5); the father's presence during newborn resuscitation in the delivery room has only been reported in terms of the impact on the father (6).

The experiences of HCPs of the presence of a relative during the resuscitation of a family member has been investigated in settings such as adult and paediatric intensive care and accident and emergency (7,8,9). Early 'witnessed resuscitation' (WR) research identified that HCPs had a generally negative view of this experience (10). In addition to the potentially harmful psychological effect and physical risks to the relatives, HCPs felt WR would impinge on themselves and their practice in a

1
2
3 negative way (8,11,12). However, despite some initial opposition, most HCPs now
4
5 embrace the concept of WR and it has become accepted practice in many Western
6
7 countries over the last two decades. This reflects a generally more open and
8
9 inclusive approach to health care and recognition of the need to deliver family-
10
11 centred care (13,14).
12

13
14
15
16 The feelings and perceptions of HCPs' experiences of the father's presence during
17
18 newborn resuscitation in the delivery room have not previously been investigated.
19
20 These phenomena were explored as part of a study of father's experiences of
21
22 childbirth and the immediate care of their baby (6). The aim of this part of the wider
23
24 study was to gain a broader understanding of fathers' experiences through HCPs'
25
26 accounts of episodes of care. Participants also reflected on the ways in which the
27
28 father's presence impacted on themselves and their practice. This paper focuses on
29
30 the findings pertaining to the experiences of HCPs of the father's presence during
31
32 newborn resuscitation.
33
34
35
36
37

38 **METHOD**

39 **Participants**

40
41
42
43 A purposive sample of 37 HCPs including midwives, obstetricians, anaesthetists,
44
45 neonatal nurse practitioners, neonatal nurses and paediatricians was recruited from
46
47 one large teaching hospital in the UK (Table 1). The only inclusion criterion was that
48
49 the HCP had experience of neonatal resuscitation in the delivery room when the
50
51 baby's father was present. No exclusion criteria were identified. Participants were
52
53
54
55
56
57
58
59
60

1
2
3 recruited using a range of strategies: posters inviting HCPs to take part were
4 displayed in various locations within the maternity unit and NNU; HCP meetings
5 were attended to discuss the study and information leaflets were distributed in the
6 delivery suite and NNU. Some participants also recommended other HCPs. In
7 accordance with the critical incident approach, recruitment continued until a range of
8 HCPs who had encountered a variety of experiences was recruited (15).
9
10
11
12
13
14
15
16
17

18 Six HCPs approached about the study decided not to take part (2 midwives and 4
19 neonatal nurses). Another six said they would participate but staff shortages and
20 workload issues meant that the interview did not take place (2 midwives, 2 neonatal
21 nurses, 1 paediatrician and 1 obstetrician). The sample included participants with
22 diverse clinical backgrounds and experience (16) (Table 1). Detail regarding the
23 participants' ages has not been included to safeguard their anonymity. The
24 participants were from a range of ethnic backgrounds corresponding to the main
25 groups represented in the study site's local population. The relatively high number of
26 neonatal nurses interviewed is because this part of the study also explored HCPs'
27 experiences of the father's first visit to his baby on the NNU (not reported here). All
28 the neonatal nurses who participated in this phase of the study, regularly attended
29 delivery suite to support other staff during newborn resuscitation.
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46

47 **INTERVIEWS**

48
49
50 Semi-structured, qualitative interviews were undertaken using the critical incident
51 approach (17). Participants were asked to select an incident involving newborn
52 resuscitation in the delivery room when they and the baby's father had been present.
53
54
55
56
57
58
59
60

1
2
3 They described what happened and how those present, particularly the father,
4 responded (15,18). The interviewer (MH) used key questions and follow-up
5 questions to facilitate the description of events and to explore HCP perceptions and
6 feelings. This flexible approach enabled HCPs to describe what happened and their
7 feelings in their own words (19,20). In order to ensure a range of scenarios were
8 explored, participants were then asked to describe a contrasting incident (21,22).
9
10 The interviews ranged between 22 and 78 minutes (mean 48 minutes). Participants
11 were interviewed in a private room within the Hospital. Most of the interviews took
12 place on weekday afternoons within the HCP's working day. With participant
13 informed consent, the interviews were tape-recorded to enable verbatim transcription
14 and data analysis. At the end of the interview, participants were given a debriefing
15 sheet identifying possible sources of support. In accordance with qualitative
16 methods; data collection, transcription and data analysis were carried out
17 concurrently (20,23). The study was approved by the Solihull Local Research Ethics
18 Committee (05/Q2706/104). University and trust approvals were also obtained. All
19 participants gave informed consent immediately before the interview.
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39

40 ANALYSIS

41
42
43
44
45 Thematic analysis was undertaken using the software package 'NVivo 7'. The first
46 transcript was coded into themes. These were organized into themes, each of which
47 contained a number of related sub-themes. Subsequent transcripts were then
48 analysed and additional themes or sub-themes were generated when the data
49 captured something new. 'NVivo' software was used to facilitate the process as it
50 facilitates the identification of relationships between the themes (24). Data collection
51
52
53
54
55
56
57
58
59
60

1
2
3 continued until no new themes were identified (data saturation) (19,25). The themes
4
5 and sub-themes were reviewed and amended until the final framework was agreed
6
7 by both authors.
8
9

10 11 **RESULTS**

12
13
14
15
16 Analysis of the data generated four themes: 'whose role?' 'saying and doing,'
17
18 'teamwork' and 'impact on me' which are described and illustrated with direct
19
20 quotations.
21
22
23

24 25 **Whose role?**

26
27
28
29 This theme focuses on which HCP supported and communicated with the father
30
31 during and after the resuscitation. In the events described no-one exclusively took
32
33 on these roles during the incident and no-one was delegated to do so. This was
34
35 because HCP attention was focused on delivering care to the mother and/or baby
36
37 (Table 2 – 2.1). Whilst all HCP groups felt the midwife was the most appropriate
38
39 person to support and communicate with the father, they acknowledged that she had
40
41 other responsibilities at the time (Table 2 – 2.2). Communication with the parents
42
43 during the resuscitation was usually directed towards the mother. Participants
44
45 thought this was appropriate because unlike the father, most mothers could not see
46
47 what was happening. In addition, HCPs believed that fathers could hear what was
48
49 being said. Consequently fathers received limited direct information and support and
50
51 this was generally only given on an 'ad hoc' basis.
52
53
54
55
56
57
58
59
60

1
2
3 Any information that was given to fathers during the resuscitation was usually
4
5 provided by an anaesthetist or midwife. This was most commonly general
6
7 information because they did not feel it was their responsibility to give more detail at
8
9 this time. On occasions when the resuscitation was prolonged neonatal nurses
10
11 sometimes went over to the parents to explain what was happening when the baby's
12
13 condition had been stabilised (Table 2 – 2.3). Once resuscitation was completed
14
15 some babies required NNU admission whilst others remained with their parents.
16
17 Paediatricians, neonatal nurse practitioners and neonatal nurses described speaking
18
19 to the parents at this time. However, midwives also recalled advocating for parents
20
21 by prompting paediatricians to speak to parents before they left the delivery room.
22
23 All HCP groups discussed whether they debriefed the fathers after the resuscitation.
24
25 Most midwives described attempting to speak to the father by himself to explain what
26
27 had happened and correct misunderstandings. However, in many instances this was
28
29 not possible because of other demands or lack of opportunity. Anaesthetists and
30
31 obstetricians felt it was not appropriate for them to debrief fathers and although
32
33 paediatricians, neonatal nurse practitioners and neonatal nurses recalled instances
34
35 when they had done this, the discussion was usually initiated by the father days or
36
37 weeks later, when the baby was being cared for in the NNU. A general reluctance to
38
39 get involved in these discussions was reported, particularly amongst neonatal nurses
40
41 who had been present during the resuscitation (Table 2 – 2.4). They felt
42
43 uncomfortable discussing events particularly if they thought the father would become
44
45 distressed. They were also concerned about being asked questions they could not
46
47 answer.
48
49
50
51
52
53
54
55

56 **Saying and doing**

57
58
59
60

1
2
3
4
5 Participants reflected on factors that influenced what they said to fathers and the
6
7 ways they supported them during and after the resuscitation. Anaesthetists and
8
9 midwives acknowledged that they usually only gave fathers general information
10
11 during the resuscitation because they were uncertain what was happening or how
12
13 the baby was responding. However, they tried to say something positive such as
14
15 commenting on the amount or colour of the baby's hair.
16
17
18
19

20
21 When paediatricians, neonatal nurse practitioners and neonatal nurses spoke to
22
23 parents after the resuscitation the information given varied, ranging from detailed
24
25 information to a more general summary of events. Needing to get the baby to the
26
27 NNU as quickly as possible appeared to influence the nature and extent of
28
29 information given. Consequently parents whose baby required more extensive
30
31 resuscitation were often given the least amount of information.
32
33
34
35

36 Being able to draw on previous experience and background knowledge was felt to be
37
38 invaluable. However, most participants had not received any education or training
39
40 about communicating with fathers, either generally or in specific situations such as
41
42 newborn resuscitation. More senior HCPs also said they did not address these
43
44 issues in their teaching (Table 3 – 3.1). Midwives who had trained more recently had
45
46 received some teaching about supporting fathers in general, but this was minimal. All
47
48 HCPs felt their way of supporting and communicating with fathers had evolved
49
50 through experience. Some midwives and anaesthetists felt they had become skilled
51
52 at observing non-verbal cues portrayed by fathers and this enabled them to support
53
54 them more effectively. Other HCPs drew on experience in related specialties, taking
55
56
57
58
59
60

1
2
3 personal responsibility for their own learning, discussions with fathers and reflection
4
5 on their practice (Table 3 – 3.2).
6
7

8
9
10 In developing their ways of supporting and communicating with fathers, HCPs said
11 they drew on two other elements: observing the practice of others and thinking about
12 how they would like to be treated. They described learning from mentors, senior
13 colleagues, their peers or junior staff, and recalled both positive and negative
14 scenarios (Table 3 – 3.3). Obstetricians often specifically mentioned learning good
15 practice from midwives. Several HCPs used the phrase “putting yourself in their
16 shoes.” Female HCPs modified this approach to thinking about how they would like
17 their partner to be treated (Table 3 – 3.4). Despite the various strategies developed
18 over time all HCP groups said they often did not know what to say to fathers during
19 prolonged episodes of resuscitation (Table 3 – 3.5).
20
21
22
23
24
25
26
27
28
29
30
31
32
33

34 **Teamwork**

35
36
37
38 Participants identified the importance of effective teamwork during the resuscitation.
39 They felt that when the team worked well together, the situation was usually dealt
40 with quickly and smoothly to the benefit of all concerned, including the father. Senior
41 HCPs described having an ‘instinctive’ way of working with their colleagues such that
42 verbal communication was not required. They described scenarios when those
43 present spontaneously took on different roles and responsibilities assisting and
44 supporting each other (Table 4 – 4.1). Obstetricians and anaesthetists recalled
45 distracting the father so their colleagues could focus on the resuscitation.
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100
101
102
103
104
105
106
107
108
109
110
111
112
113
114
115
116
117
118
119
120
121
122
123
124
125
126
127
128
129
130
131
132
133
134
135
136
137
138
139
140
141
142
143
144
145
146
147
148
149
150
151
152
153
154
155
156
157
158
159
160
161
162
163
164
165
166
167
168
169
170
171
172
173
174
175
176
177
178
179
180
181
182
183
184
185
186
187
188
189
190
191
192
193
194
195
196
197
198
199
200
201
202
203
204
205
206
207
208
209
210
211
212
213
214
215
216
217
218
219
220
221
222
223
224
225
226
227
228
229
230
231
232
233
234
235
236
237
238
239
240
241
242
243
244
245
246
247
248
249
250
251
252
253
254
255
256
257
258
259
260
261
262
263
264
265
266
267
268
269
270
271
272
273
274
275
276
277
278
279
280
281
282
283
284
285
286
287
288
289
290
291
292
293
294
295
296
297
298
299
300
301
302
303
304
305
306
307
308
309
310
311
312
313
314
315
316
317
318
319
320
321
322
323
324
325
326
327
328
329
330
331
332
333
334
335
336
337
338
339
340
341
342
343
344
345
346
347
348
349
350
351
352
353
354
355
356
357
358
359
360
361
362
363
364
365
366
367
368
369
370
371
372
373
374
375
376
377
378
379
380
381
382
383
384
385
386
387
388
389
390
391
392
393
394
395
396
397
398
399
400
401
402
403
404
405
406
407
408
409
410
411
412
413
414
415
416
417
418
419
420
421
422
423
424
425
426
427
428
429
430
431
432
433
434
435
436
437
438
439
440
441
442
443
444
445
446
447
448
449
450
451
452
453
454
455
456
457
458
459
460
461
462
463
464
465
466
467
468
469
470
471
472
473
474
475
476
477
478
479
480
481
482
483
484
485
486
487
488
489
490
491
492
493
494
495
496
497
498
499
500
501
502
503
504
505
506
507
508
509
510
511
512
513
514
515
516
517
518
519
520
521
522
523
524
525
526
527
528
529
530
531
532
533
534
535
536
537
538
539
540
541
542
543
544
545
546
547
548
549
550
551
552
553
554
555
556
557
558
559
560
561
562
563
564
565
566
567
568
569
570
571
572
573
574
575
576
577
578
579
580
581
582
583
584
585
586
587
588
589
590
591
592
593
594
595
596
597
598
599
600
601
602
603
604
605
606
607
608
609
610
611
612
613
614
615
616
617
618
619
620
621
622
623
624
625
626
627
628
629
630
631
632
633
634
635
636
637
638
639
640
641
642
643
644
645
646
647
648
649
650
651
652
653
654
655
656
657
658
659
660
661
662
663
664
665
666
667
668
669
670
671
672
673
674
675
676
677
678
679
680
681
682
683
684
685
686
687
688
689
690
691
692
693
694
695
696
697
698
699
700
701
702
703
704
705
706
707
708
709
710
711
712
713
714
715
716
717
718
719
720
721
722
723
724
725
726
727
728
729
730
731
732
733
734
735
736
737
738
739
740
741
742
743
744
745
746
747
748
749
750
751
752
753
754
755
756
757
758
759
760
761
762
763
764
765
766
767
768
769
770
771
772
773
774
775
776
777
778
779
780
781
782
783
784
785
786
787
788
789
790
791
792
793
794
795
796
797
798
799
800
801
802
803
804
805
806
807
808
809
810
811
812
813
814
815
816
817
818
819
820
821
822
823
824
825
826
827
828
829
830
831
832
833
834
835
836
837
838
839
840
841
842
843
844
845
846
847
848
849
850
851
852
853
854
855
856
857
858
859
860
861
862
863
864
865
866
867
868
869
870
871
872
873
874
875
876
877
878
879
880
881
882
883
884
885
886
887
888
889
890
891
892
893
894
895
896
897
898
899
900
901
902
903
904
905
906
907
908
909
910
911
912
913
914
915
916
917
918
919
920
921
922
923
924
925
926
927
928
929
930
931
932
933
934
935
936
937
938
939
940
941
942
943
944
945
946
947
948
949
950
951
952
953
954
955
956
957
958
959
960
961
962
963
964
965
966
967
968
969
970
971
972
973
974
975
976
977
978
979
980
981
982
983
984
985
986
987
988
989
990
991
992
993
994
995
996
997
998
999
1000

1
2
3 junior paediatrician was having difficulty intubating the baby. Several midwives
4 described responding to a crash call. They often took on the role of 'go-between,'
5
6 relaying information between the neonatal and obstetric teams and the parents. The
7
8 importance of senior HCPs supporting junior staff was also identified (Table 4 – 4.2).
9
10

11 12 13 14 **Impact on me**

15
16
17
18 During the interviews, the HCPs frequently reflected on the impact of the event on
19 themselves. During the resuscitation, HCPs described trying to adopt a calm and
20 self-assured manner regardless of how they were feeling. They hoped this attitude
21 would be transmitted to the father and as a consequence, he would be comforted
22 and reassured. Many midwives however, said it was difficult to adopt this approach
23 and when recounting specific events described them as being “awful”, “horrendous”,
24
25 “terrible” and “shocking.” Five HCPs (midwives and neonatal nurses) cried as they
26 recalled the resuscitation and on two occasions, the recording was temporarily
27 stopped. In a less extreme way, when they reflected on specific events, several
28 midwives felt they should have done more to support the father (Table 5 – 5.1).
29
30
31
32
33
34
35
36
37
38
39
40
41
42

43 Another issue some paediatricians and the neonatal nurse practitioners talked about
44 was when the father approached the resuscitator during the resuscitation. The
45 neonatal nurse practitioners and some of the more senior paediatricians were
46 comfortable with this and felt it did not impact on their practice in a negative way
47 (Table 5 – 5.2). Others however, felt uneasy being watched so closely and felt it
48 placed additional stress on them in an already pressurised situation (Table 5 – 5.3).
49
50
51
52
53
54
55
56
57
58
59
60

1
2
3 The HCPs rarely said the events they described had a positive impact on them. Their
4 relief and satisfaction when all was well was usually implied rather than stated. This
5 may be because in many cases, the busy nature of the care setting meant that they
6 often quickly became involved in the care of other parents and babies with limited
7 opportunity to reflect on what had happened. Midwives were the only HCPs who
8 described becoming emotional when the resuscitation was successful. This is
9 probably because in most cases they had been directly involved in the couple's care
10 during labour.
11
12
13
14
15
16
17
18
19

20 21 22 23 24 25 **DATA SHARING**

26
27
28
29 No additional data available.
30
31
32

33 34 35 **DISCUSSION**

36
37
38 This is the first reported study to explore the experiences and perceptions of HCPs
39 involved in neonatal resuscitation in the delivery room when the baby's father was
40 present. The interviews provide strong evidence of HCPs' perspectives of this type of
41 scenario. Although all HCP groups said the fathers needed support and information
42 during the resuscitation, it was acknowledged these needs were almost always
43 unmet. This confirms a finding from an earlier phase of the broader study (6). In most
44 cases HCPs felt their priorities at the time were the health of the baby or the mother.
45 Although HCPs thought the midwife was probably best placed to support the father it
46 was acknowledged that that she had a duty of care to the mother and was often
47
48
49
50
51
52
53
54
55
56
57
58
59
60

1
2
3 involved in her ongoing care. A key factor in the failure to meet the needs of fathers
4
5 appeared to be that none of the professional groups involved had direct
6
7 responsibility to support and communicate with him. It was frequently stated that “he
8
9 wasn’t my patient.”
10

11
12
13
14
15
16 Most HCPs were aware that in other care settings a designated HCP often supports
17
18 relatives when they witness resuscitation events (8,26,27). The role of the chaperone
19
20 is to explain what is happening and to support, reassure, and de-brief the relative.
21
22 They can also intervene if the relative’s behaviour becomes distracting (14,26). This
23
24 role is generally undertaken by a senior HCP, usually a nurse, who can provide
25
26 appropriate information and support (26). Whilst the HCPs suggested a chaperone
27
28 would be beneficial for fathers, it was felt staff shortages and lack of resources would
29
30 prevent this from happening.
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

The HCPs identified a number of factors that could have added to what would have
already been a difficult experience for fathers. These factors included a lack of direct
information at key points and situations where fathers were excluded or
marginalised. Many HCPs also described the impact of events on them and aspects
they found difficult. An issue that frequently occurred was what to say during
prolonged resuscitation. Experienced HCPs as well as those who had been working
in the specialty for a short time identified this difficulty. The more acute distress
displayed by midwives and neonatal nurses during the interviews was most
commonly because they felt the situation was not handled well and they felt culpable

1
2
3 to some extent. Obstetricians, anaesthetists and paediatricians were more 'matter-
4 of-fact' about what happened and did not appear to feel responsible when a father's
5 needs were not met. However, paediatricians described their discomfort when
6 fathers came to the resuscitaire. This may indicate a lack of confidence in their ability
7 or their recognition that the presence of the father can cause additional pressure at
8 an already stressful time. This was explored in the early literature regarding WR in
9 other care settings which reports that HCPs felt WR would have a negative impact
10 on their practice (8,11,12). However, over time HCPs who have been exposed to
11 WR have found ways to accommodate it in their practice.
12
13
14
15
16
17
18
19
20
21
22
23
24

25 Guidance about supporting parents in the delivery room is given in the recently
26 updated European and UK newborn life-support training programmes, mainly in
27 relation to communicating with parents before, during and after the event (28,29).
28 However, no specific guidance is given about ways to communicate with or ways to
29 support the father. This would appear to be an area worthy of development given the
30 lack of confidence that some HCPs expressed about communicating with fathers
31 during resuscitation events, particularly when the resuscitation was prolonged.
32
33
34
35
36
37
38
39
40
41
42

43 **STRENGTHS AND LIMITATIONS**

44
45
46
47 The critical incident approach proved to be an appropriate way to explore HCPs'
48 experiences of specific events. Asking participants to focus on the father enabled
49 many of them to consider the impact of newborn resuscitation on fathers for the first
50 time. Although participants sometimes talked about the parents collectively, the
51 interviewer's subsequent probing questions encouraged them to concentrate on their
52
53
54
55
56
57
58
59
60

1
2
3 experience with fathers. Some participants chose to describe events that occurred a
4
5 while ago. However, they had no difficulty remembering what happened and their
6
7 feelings at the time. As their description of events progressed, the HCPs were often
8
9 surprised at how clearly they could recall what happened. Whilst some found
10
11 describing events upsetting; none wished to discontinue the interview. None of the
12
13 HCPs chose to describe an incident where the baby did not survive. HCPs may have
14
15 thought that this was what was required, although this was not stated by the
16
17 interviewer. Alternatively, they may have deliberately elected not to recall an incident
18
19 that they thought they would find too sensitive or potentially controversial to discuss.
20
21 Although undertaken in one setting, the findings from this independent study provide
22
23 insight to the experiences and perceptions of HCPs and the context in which the
24
25 resuscitation events occurred (19). The extent to which the findings apply to other
26
27 HCPs encountering newborn resuscitation can therefore be considered. To gain a
28
29 broader view of HCPs' experiences and the longer term impact, this study could be
30
31 replicated with larger groups of HCPs. It would also be valuable to explore the
32
33 experiences of HCPs where the baby did not survive the resuscitation. Although
34
35 such a study would present challenges, it would have the potential to provide insight
36
37 to situations that could have profound and possibly long lasting effects on HCPs.
38
39 This in turn could influence the provision of HCP education, training and support in
40
41 the future.
42
43
44
45
46
47
48

49 **IMPLICATIONS FOR PRACTICE**

50
51
52
53
54 To some extent newborn resuscitation is part of the normal working day for many
55
56 HCPs involved in neonatal care. However, some midwives and neonatal nurses
57
58
59
60

1
2
3 became distressed when discussing events some of which occurred some time ago
4
5 and yet remained a strong memory. This suggests there is a need for greater
6
7 recognition of the impact of resuscitation events on HCPs. The provision of
8
9 opportunities for formal and informal reflection on practice, debriefing and support
10
11 could be more extensive.
12
13

14
15
16 The HCPs were generally aware of the needs of fathers during and after newborn
17
18 resuscitation. However, a number of difficulties and challenges affected how they
19
20 supported and communicated with fathers. Whilst there is increasing evidence
21
22 pertaining to the needs of fathers, in maternity care, HCPs generally focus on the
23
24 needs of mothers and babies (30); duty of care and professional responsibilities
25
26 determine this. Nevertheless, it would appear that there is scope for much more
27
28 extensive HCP education and training about supporting and communicating with
29
30 fathers around the time of newborn resuscitation. The allocation of resources to
31
32 support the provision of a chaperone for fathers during resuscitation would also be
33
34 worthy of consideration by service providers (8,14).
35
36
37
38
39

40 **ACKNOWLEDGEMENTS**

41
42
43
44
45 We would like to thank the health care professionals who participated in this study
46
47 and were willing to share their experiences so readily.
48
49

50 **COMPETING INTERESTS**

1
2
3 Both authors have completed the Unified Competing Interest form at
4
5 http://www.icmje.org/coi_disclosure.pdf (available on request from the corresponding
6
7 author) and declare: no support from any organisation for the submitted work; no
8
9 financial relationships with any organisations that might have an interest in the
10
11 submitted work in the previous three years, no other relationships or activities that
12
13 could appear to have influenced the submitted work.
14
15
16
17
18
19
20
21
22
23

24 25 **FUNDING**

26
27
28
29 Development and approval of the study, participant recruitment, data collection and
30
31 initial data analysis were undertaken when the first author held the Bliss Neonatal
32
33 Nurse Research Fellow post at the National Perinatal Epidemiology Unit, University
34
35 of Oxford. The first author's PhD fees were met by Birmingham City University and
36
37 the first author. All other expenses were met by the first author. Aston University was
38
39 the sponsor. This included providing University approval for the study and ensuring
40
41 the study was carried out in accordance with the Research Governance Framework.
42
43
44
45
46
47
48

49 50 **AUTHORS' CONTRIBUTIONS**

51
52
53
54 Dr M.E Harvey (MH) developed and designed the research proposal, negotiated
55
56 access to the study-site, obtained the required approvals, recruited participants,
57
58
59
60

1
2
3 conducted the interviews, undertook the data analysis and wrote the first draft of this
4
5 paper. Professor HM Pattison (HP) supervised MH throughout the study, agreed the
6
7 coding framework, contributed to and has agreed the final version of the paper. MH
8
9 is the guarantor.
10

11
12
13
14 The Corresponding Author has the right to grant on behalf of all authors and does
15
16 grant on behalf of all authors, an exclusive licence on a worldwide basis to the BMJ
17
18 Publishing Group Ltd and its Licensees to permit this article (if accepted) to be
19
20 published in BMJ editions and any other BMJ PGL products and sub-licences to
21
22 exploit all subsidiary rights, as set out in our licence.
23
24

25 REFERENCES

- 26
27
28 1. Kiernan K, Smith K. Unmarried Parenthood: New Insights from the Millennium
29
30 Cohort Study. *Popul Trends*. 2003;26-33
31
32
33
34 2. TNS System Three. *NHS Maternity Services Quantitative Research*.
35
36 Edinburgh: TNS System Three 2005;44-57
37
38
39
40
41 3. Murthy V, Rao N, Fox GF, Milner AD, Campbell M, Greenough A. Survey of
42
43 UK newborn resuscitation practices. *Arch Dis Child Fetal Neonatal Ed*.
44
45 2012;97:F154-5
46
47
48
49 4. Fulbrook P, Latour JM, Albarra, JW. Paediatric critical care nurses' attitudes
50
51 and experiences of parental presence during cardiorespiratory resuscitation:
52
53 A European survey. *Int J Nurs Stud*. 2007;44:1238-1249
54
55
56
57
58
59
60

- 1
2
3 5. Perry SE. Support for parents witnessing resuscitation: nurse perspectives.
4
5 *Paed Nurs.* 2009;21:26-31
6
7
8
- 9
10 6. Harvey ME, Pattison HM, Being there: a qualitative interview study with
11
12 fathers present during the resuscitation of their baby at delivery. *Arch Dis*
13
14 *Child Fetal Neonatal Ed.* 2012;97:F439-F443
15
16
17
18
19
- 20
21 7. Sacchetti A, Carraccio C, Leva E, Harris RH, Lichenstein R. Acceptance of
22
23 family member presence during pediatric resuscitations in the emergency
24
25 department: Effects of personal experience. *Pediatr Emerg Care.* 2000;
26
27 16:85-87
28
29
30
31
32
33
- 34 8. Grice AS, Picton P, Deakin CDS. Study examining attitudes of staff,
35
36 paediatrics and relatives to witnessed resuscitation in adult intensive care
37
38 units. *Br J Anaesth.* 2003;91:820-824
39
40
41
42
43
- 44 9. Fulbrook P, Albarran JW, Latour JM. A European survey of critical care
45
46 nurses' attitudes and experiences of having family members present during
47
48 cardiorespiratory resuscitation *Int J Nurs Stud.* 2005;42:557-568
49
50
51
- 52 10. McGahey PR. Family presence during pediatric resuscitation: focus on staff
53
54
55 *Critic Care Nurs.* 2002;22:29-34
56
57
58
59
60

- 1
2
3 11. Schilling RJ. Should relatives watch resuscitation? – No room for spectators
4
5 *BMJ*. 1994;309:406
6
7
8
9
10 12. MacLean SL, Guzzetta CE, White C, Fontaine D, Eichhorn DJ, Meyers TA et
11
12 al. Family presence during cardiopulmonary resuscitation and invasive
13
14 procedures: practices of critical care and emergency nurses *Am J Crit Care*.
15
16 2003;12:246- 257
17
18
19
20 13. American Academy of Pediatrics. Family-Centred Care and the Pediatricians
21
22 Role *Pediatrics*. 2003;112:691-696
23
24
25
26
27 14. Baskett PJF, Steen PA, Bossaert L. European Resuscitation Council
28
29 Guidelines for Resuscitation 2005 - Section 8. The ethics of resuscitation and
30
31 end-of-life decisions *Resuscitation*. 2005;67:S171-S180
32
33
34
35
36
37 15. Broström A, Strömberg A, Dahlström U, Fridlund B. Congestive heart failure,
38
39 spouses' support and the couple's sleep situation: a critical incident technique
40
41 analysis *J Clin Nurs*. 2003;12: 223-233
42
43
44
45
46 16. O'Leary Z. *The Essential Guide to Doing Research*. London: Sage
47
48 Publications 2004
49
50
51
52
53 17. Flanagan JC. The critical interview technique *Psychology Bulletin*.
54
55 1954;51:327-358
56
57
58
59
60

- 1
2
3 18. Sharoff L. Critique of the critical incident technique *J Res Nurs*. 2008;13:301-
4 309
5
6
7
8
9
10 19. Pope C, Campbell R. Qualitative research in obstetrics and gynaecology. *Brit*
11 *J Obstet Gynaec*. 2001;108:233-237
12
13
14
15
16 20. Kvale S, Brinkmann S. *Interviews: Learning the Craft of Qualitative Research*
17 *Interviewing*. Second edition. Los Angeles: Sage 2009
18
19
20 21. Robson C. *Real world research*. Third edition. Oxford: Blackwell Publishing
21 2012
22
23
24
25
26
27 22. Silvester J. Work and Organizational Psychology in Willig C, Stainton-Rogers
28 *W. The Sage Handbook of Qualitative Research in Psychology*. London:
29 Sage Publications 2008
30
31
32
33
34
35
36
37 23. Pope C, Ziebland S, Mays N. Analysing qualitative data. *BMJ*. 2000;320:114-
38 116
39
40
41
42
43
44 24. Lewins A, Silver C. *Using software in qualitative research*. London: Sage
45 Publications 2007
46
47
48
49
50 25. Malterud K. Qualitative research: standards, challenges and guidelines.
51 *Lancet*. 2001;358:483-488
52
53
54
55
56
57
58
59
60

- 1
2
3 26. Goldstein A, Berry K, Callaghan A. Resuscitation witnessed by relatives has
4
5 proved acceptable to doctors in paediatric cases. *BMJ*. 1997;314:144-145
6
7
8
9
10 27. Robinson SM, Mackenzie-Ross S, Campbell Hewson GL, Egleston CV,
11
12 Prevost AT. Psychological effect of witnessed resuscitation on bereaved
13
14 relatives. *Lancet*. 1998;352:614-617
15
16
17
18 28. Nolan JP, Soar J, Zideman DA, *et al* European Resuscitation Council
19
20 Guidelines for Resuscitation 2010 Section 1. Executive summary.
21
22 *Resuscitation*. 2010;81:1219-1276
23
24
25
26
27 29. Resuscitation Council. *Resuscitation at birth*. Third edition. London:
28
29 Resuscitation Council (UK) 2011
30
31
32
33
34 30. McVeigh CA, Baafi M, Williamson M. Functional status after fatherhood: An
35
36 Australian study. *J Obstet Gynecol Neonatal Nurs*. 2002;31:165-171
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

HCP Group	No.	Sex	Time from initial qualification	Length of time in current post
Midwives	12	Female*	1 – 29 years	6 months – 5 years
Neonatal nurses	10	Female*	2 – 32 years	6 months – 23 years
Neonatal nurse practitioners	2	Female*	7 – 19 years	6 months – 7 years
Obstetricians	3	Female	9 – 22 years	1 – 6 years
Anaesthetists	4	2 Female 2 Male	6 – 16 years	1 – 6 years
Paediatrician	6	1 Female 5 male	2 – 33 years	2½ months – 18 years

*No males were employed in this role during the period of recruitment

Table 1 Participant biographical details

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Table 2	Whose role?
2.1	<i>"My main focus is the mother. I think that's, I think it's important to understand that because the mother's my patient, the father's not my patient."</i> (Anaesthetist14)
2.2	<i>"When the baby was born and she needed resuscitating, he ran out the room crying. I felt like I should have ran after him really which I couldn't at the time because I was trying to like stop her ((the mother)) from bleeding. So it was difficult but I did think, oh my God."</i> (Midwife9)
2.3	<i>"I at that time, I could not speak to dad because we, our priority was the baby and baby needed intubating. Once that was done I was able to then go and speak to mum just to give her brief information of what was going on, how the baby was."</i> (NeonatalNurse1)
2.4	<i>"It's not my place, just in case he asked me sensitive questions that I'm not able to answer. It's very difficult in that situation especially if you've got a very sick baby. I would not take part in that at all."</i> (NeonatalNurse5)

Table 3 **Saying and doing**

- 3.1 *"I don't think it's anything that anybody's spoken about and I suppose I don't really speak to the trainees who come through about it either."*
(Paediatrician16)
- 3.2 *"I think my practice is probably based on what I've heard husbands and partners tell me and how they felt."* (Midwife15)
- 3.3 *"I have a series of horror stories of observing my consultant teachers in days of yore making a complete and utter hash of it. And I use that you know and I just, you just learn by thinking, right, if I live a thousand years, I will never do that."* (Paediatrician15)
- 3.4 *"I always say, speak to people how you would want to be spoken to. Treat them the way you want to be treated and just put yourself in their situation. You know, it's your partner, that's your baby and somebody's not even acknowledging that you're there, how would that make you feel?"* (Obstetrician61)
- 3.5 *"It was awful. No-one was saying anything and mum was crying. I was just thinking please, please somebody say something."*
(NeonatalNurse7)
-

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Table 4	Teamwork
4.1	<i>"If I'm happy the mother's suturing is done and mum's not bleeding, mum's fine and everybody is working on the baby then I will stay and do whatever I can whether it's fetching for the paediatrician or whether it's staying and supporting mum and dad because the midwife's helping the paediatrician."</i> (Obstetrician10)
4.2	<i>"It's like yesterday the shoulder dystocia, the baby needed to be resuscitated. Me and the Shift Leader talked about it, like you know, you go over it like, oh that was awful and, oh he ((the father)) was crying, oh it was terrible and you just talk about it and then that helps you to kind of deal with what's happened."</i> (Midwife9)

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Table 5	Impact on me
5.1	<i>“You try and support the fathers and meet their needs when it happens. I do have days where I go home deflated thinking I really wish I could have done more for him that day.” (Midwife12)</i>
5.2	<i>“I don’t mind it at all. I’m used to people watching what I do and I think he needs to see anyway.” (NeonatalNursePractitioner14)</i>
5.3	<i>“I don’t like it. Not because it’s a worry to me it’s just because I don’t happen to like being watched when I’m working.” (Paediatrician7)</i>
5.4	<i>“Yes. Even now, after all this time, there are some difficult deliveries and you want to, you share in all of that emotion and it’s very easy to kind of get prickly eyes when the baby is ok.” (Midwife7)</i>

Interview schedule

Opening statement: **This interview forms part of a larger study that aims to gain an understanding of the experiences and perceptions of fathers who attend the birth of their baby, especially when the baby has required resuscitation at birth and / or admission to a neonatal unit.**

Within this interview I am particularly interested in your experience of situations when a sick / preterm baby is delivered, requires resuscitation at birth and / or admission to a neonatal unit, and the baby's father is present. Before consideration of key issues, can I clarify the following?

Job title / Qualifications / Length of time qualified / Length of time this post

KEY ISSUES TO EXPLORE

There are a variety of situations that you might have experienced:

- **The antenatal preparation of fathers (i.e. before labour has started) particularly if the birth of a sick / preterm baby is anticipated.**
- **Being at the delivery of a sick / preterm baby when the baby's father is also present.**
- **Being at the resuscitation of a newborn baby when the baby's father is also present.**
- **Being present when a baby is admitted to the neonatal unit when the baby's father is also present.**

Which of the above do you have experience of?

When was the last time that you encountered each situation?

(check each individual situation)

So, for the purpose of this interview we'll be talking about you

- *Being involved in the antenatal preparation of fathers (i.e. before labour has started) particularly if the birth of a sick / preterm baby is anticipated.*
- *Being at the delivery of a sick / preterm baby when the baby's father is also present.*
- *Being at the resuscitation of a newborn baby when the baby's father is also present.*
- *Being present when a baby is admitted to the neonatal unit when the baby's father is also present.*

Can you recall an occasion you were involved with relating to

Follow up any specific information to clarify description of events.

Clarify participant's role in the situation – what did you do / say?

Why does this case particularly spring to mind?

Is there anything that you'd like to add, particularly regarding what happened to the father?

Follow up any specific information to clarify description of events.

Clarify participant's role in the situation – what did you do / say?

Do you know if the father wanted to be there?

Thinking back to that occasion, do you think that the situation went well or not as well as it could have done?

1
2
3 *Why do you think this was the case?*

4
5 **What about the father in this case? – looking at it from his perspective – did it go well**
6 **or not as well as it could have done?**

7 *Why do you think this was the case?*

8
9 **Can you recall a contrasting situation you were involved with, by that I mean one that**
10 **didn't / did go well?– can you tell me about that?**

11 *Follow up any specific information to clarify description of events.*

12 *Clarify details / participant's role in the situation – what did you do / say?*

13 *What do you think were the key issues that made this situation different to the previous*
14 *case?*

15 *Why does this case particularly spring to mind?*

16
17
18 **Is there anything that you'd like to add, particularly regarding what happened to the**
19 **father?**

20 *Follow up any specific information to clarify description of events.*

21 *Clarify participant's role in the situation – what did you do / say?*

22 *From his perspective do you think that he'd say it went well or not as well as it could have*
23 *done?*

24 *Clarify participant's role in the situation – what did you do / say?*

25
26 **What do you suppose fathers feel that they need in terms of information / support**
27 **antenatally / prior to the delivery / resuscitation / admission of their baby?**

28 *On what basis do you say this?*

29 *In your experience, do you think this happens in reality?*

30 *Why does / doesn't this happen?*

31 *What do think are the issues that a health care professional should consider when*
32 *supporting a father at this time?*

33 *Do you think that different fathers have different needs? – if so – how do you determine*
34 *individual needs?*

35 *Which health care professional group do you think has ultimate responsibility for supporting*
36 *fathers at this time?*

37
38 **What do you suppose fathers feel that they need in terms of information / support**
39 **during the delivery / resuscitation / admission of their baby?**

40 *On what basis do you say this?*

41 *In your experience, do you think this happens in reality?*

42 *Why does / doesn't this happen?*

43 *What do you think are the issues that a health care professional should consider when*
44 *supporting a father at this time?*

45 *Do you think that different fathers have different needs? – if so – how do you determine*
46 *individual needs?*

47 *How do you determine if the father wants to be there?*

48 *Which health care professional group do you think has ultimate responsibility for supporting*
49 *fathers at this time?*

50
51 **What do you suppose fathers feel that they need in terms of information / support**
52 **after the delivery / resuscitation / admission of their baby?**

53 *On what basis do you say this?*

54 *What impact do you think being present at..... has on fathers?*

55 *In your experience, do you think this happens in reality?*

56 *Why does / doesn't this happen?*

57 *What do you think are the issues that a health care professional should consider when*
58 *supporting a father at this time?*

1
2
3 Do you think that different fathers have different needs? – if so – how do you determine
4 individual needs?
5 Which health care professional group do you think has ultimate responsibility for supporting
6 fathers at this time?
7

8 **Can you tell me about the nature / extent of any educational preparation you've**
9 **received regarding the provision of support specifically for fathers during delivery /**
10 **resuscitation / admission to the neonatal unit?**

11 *Clarify details.*

12 *Have you participated in 'mock' incidents? For example: labour ward drill?).*

13 *Was it father / mother / parent focused?*

14 *Has this been adequate?*

15 *If no how do you now know what to do / say in these situations? What additional educational*
16 *preparation do you feel you need?*

17 *Apart from more formal educational preparation, how else have you learned what to do / say*
18 *in these situations?*
19

20 **We've talked quite a lot about the health care professional role when supporting**
21 **fathers – I'd like now to ask you to think about the impact that carrying out this role**
22 **has on you – can you tell me about that?**

23 *Positive / negative impact – particularly re: helping / supporting fathers.*

24 *Short & long-term effects.*

25 *Is this always the case or just sometimes?*

26 *If sometimes – what key factors trigger this effect on you?*

27 *Re: negative effects – how do you deal / cope with this?*

28 *In these situations is there anything that fathers could do to help you?*
29

30 **Do you have any suggestions about ways that hospitals / health care professionals**
31 **could help fathers who experience the situations we've discussed?**

32 *Follow-up any specific issues that might have been raised earlier.*

33 *Does the hospital have policies / procedures / guidelines re: supporting / care of fathers? – if*
34 *yes – clarify details – if not – why not? – do you think that there should be policies /*
35 *procedures / guidelines in place?*

36 *What advice would you give to another health care professional who might be about to*
37 *support a father in one of these situations for the first time?*
38

39 **Are there any other issues that you would like to raise in relation to these issues?**
40

41 **Can I end by asking some more information about yourself?**

42 **Age / How would you describe your ethnicity /**
43
44

45 **Thank-you very much for your help with this part of the study.**
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60



The impact of a father's presence during newborn resuscitation: a qualitative interview study with health care professionals

Journal:	<i>BMJ Open</i>
Manuscript ID:	bmjopen-2013-002547.R1
Article Type:	Research
Date Submitted by the Author:	17-Feb-2013
Complete List of Authors:	Harvey, MerryI; Birmingham City University, Child Health Pattison, Helen; Aston University, Life Health Sciences
Primary Subject Heading:	Paediatrics
Secondary Subject Heading:	Qualitative research, Paediatrics, Obstetrics and gynaecology
Keywords:	NEONATOLOGY, Neonatal intensive & critical care < INTENSIVE & CRITICAL CARE, QUALITATIVE RESEARCH

SCHOLARONE™
Manuscripts

1
2
3 **The impact of a father's presence during newborn resuscitation: a qualitative**
4
5 **interview study with health care professionals**
6
7
8
9

10
11
12 Merryl E Harvey, Helen M Pattison
13

14
15
16
17
18 Merryl E Harvey senior academic Faculty of Health, Birmingham City University,
19
20 Birmingham B15 3TN Helen M Pattison professor School of Life Health Sciences,
21
22 Aston University B4 7ET
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53

54 Correspondence to: Dr Merryl E Harvey merryl.harvey@bcu.ac.uk
55
56
57
58
59
60

ABSTRACT

Objective: To explore health care professionals' experiences around the time of newborn resuscitation in the delivery room, when the baby's father was present.

Design: A qualitative descriptive, retrospective design using the critical incident approach. Tape-recorded semi-structured interviews were undertaken with health care professionals involved in newborn resuscitation. Participants recalled resuscitation events when the baby's father was present. They described what happened and how those present, including the father, responded. They also reflected upon the impact of the resuscitation and the father's presence on themselves. Participant responses were analysed using thematic analysis.

Setting: A large teaching hospital in the UK.

Participants: Purposive sampling was utilised. It was anticipated that 35-40 participants would be recruited. Forty-nine potential participants were invited to take part. The final sample consisted of 37 participants including midwives, obstetricians, anaesthetists, neonatal nurse practitioners, neonatal nurses and paediatricians.

Results: Four themes were identified: 'whose role?' 'saying and doing' 'teamwork' and 'impact on me'. Whilst no-one was delegated to support the father during the resuscitation, midwives and anaesthetists most commonly took on this role. Participants felt the midwife was the most appropriate person support fathers. All health care professional groups said they often did not know what to say to fathers during prolonged resuscitation. Teamwork was felt to be of benefit to all concerned, including the father. Some paediatricians described their discomfort when fathers came to the resuscitaire. None of the participants had received education and training specifically on supporting fathers during newborn resuscitation.

1
2
3 **Conclusions** This is the first known study to specifically explore the experiences of
4 health care professionals of the father's presence during newborn resuscitation. The
5 findings suggest the need for more focused training about supporting fathers. There
6 is also scope for service providers to consider ways in which fathers can be
7 supported more readily during newborn resuscitation.
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

ARTICLE SUMMARY

Article Focus:

The research question for this study was; 'What are the experiences of health care professionals of the father's presence during newborn resuscitation in the delivery room?' To address this question, the objectives of this phase of the study were:

1. To conduct interviews utilising the critical incident approach with HCPs who had experience of newborn resuscitation when the baby's father was present.
2. To provide an account of the experiences of HCPs of newborn resuscitation when the baby's father was present.

Key messages:

The key messages and significance of the study are:

1. Whilst the health care professionals were aware of the information and support needs of fathers during newborn resuscitation, they acknowledged that these needs were rarely met.
2. The health care professionals in this study had not received education and training specifically about supporting fathers during newborn resuscitation.
3. The health care professionals in this study did not utilize strategies to support fathers that are recommended when relatives are present during resuscitation events in other critical care settings.

1
2
3
4
5
6
7
8 Strengths and limitations:
9

- 10
- 11 • Although undertaken in one setting, the findings from this independent study
12 provide insight to the experiences and perceptions of HCPs and the context in
13 which the resuscitation events occurred
14
 - 15 • The critical incident approach was generally an appropriate way to explore
16 HCPs' experiences of specific events. This approach enabled many of them
17 to consider the impact of newborn resuscitation on fathers for the first time.
18
 - 19 • Some participants found focusing on issues pertaining to the father more
20 difficult and sometimes talked about the mother or the parents collectively.
21 However, subsequent probing questions encouraged them to concentrate on
22 the father.
23
 - 24 • Some participants chose to describe events that occurred a while ago. It is
25 therefore difficult to determine the extent to which recall bias influenced their
26 descriptions. However, they appeared to have no difficulty remembering their
27 feelings or what happened. They were often surprised at how clearly they
28 could recall the event.
29
 - 30 • Incidents where the baby did not survive were not described. HCPs may have
31 thought the researchers were only interested in events where the baby
32 survived, although this was not stated by the interviewer. Alternatively, they
33 may have deliberately elected not to recall an incident that they thought might
34 be too sensitive or potentially controversial to discuss.
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

- Whilst the preliminary data analysis was undertaken by the first author, the thematic framework was discussed with the second author as it was developed and the final framework was agreed by both authors.
- Given the qualitative nature of this study, it is inappropriate to generalize the findings to the wider population. However, in accordance with the notion of transferability, the findings of this study have highlighted issues that may be of relevance in other settings.

INTRODUCTION

The birth of their child is often a landmark event for a father and can be an important episode in the on-going process of adaptation to parenthood. Short and more longer term benefits of a father's involvement in the life of his child have been described which can impact on the father, his partner, his baby and society more generally (1,2,3). As a consequence there has been a drive in the UK over the last 10 years to engage and involve fathers more readily, particularly during the perinatal period and during childbirth specifically (4,5,6). However, in order to ensure that fathers are appropriately supported during the perinatal period, it is important that health care professionals (HCPs) have insight to fathers' experiences and needs.

Whilst for the majority of men childbirth is straightforward, for others it is not.

When a newborn baby requires resuscitation in UK settings, the father will usually be present because most fathers attend the birth of their baby and delivery and resuscitation generally take place in the same room (7,8,9). Whilst some studies have investigated the impact on HCPs of parental presence during neonatal resuscitation in the neonatal unit (NNU) (10,11); the father's presence during newborn resuscitation in the delivery room has only been reported in terms of the impact on the father (12).

The experiences of HCPs of the presence of a relative during the resuscitation of a family member has been investigated in settings such as adult and paediatric

1
2
3 intensive care and accident and emergency (13,14,15). Early 'witnessed
4
5 resuscitation' (WR) research identified that many HCPs were not supportive of this
6
7 approach (16). They were concerned that relatives would be unduly distressed or
8
9 would be at risk of physical harm due to the nature of the environment. HCPs also
10
11 felt WR would impinge on themselves and their practice in a negative way
12
13 (14,17,18). However, despite some initial opposition, most HCPs now embrace the
14
15 concept of WR and it has become accepted practice in many Western countries over
16
17 the last two decades. This reflects a generally more open and inclusive approach to
18
19 health care and recognition of the need to deliver family-centred care (19,20).
20
21
22
23

24
25 The feelings and perceptions of HCPs' experiences and perceptions of the father's
26
27 presence during newborn resuscitation in the delivery room do not appear to have
28
29 been previously investigated. The aim of this part of a wider study (12) was to gain a
30
31 broader understanding of fathers' experiences through HCPs' accounts of episodes
32
33 of care. Participants also reflected on the ways in which the father's presence
34
35 impacted on themselves and their practice. This paper focuses on the findings
36
37 pertaining to the experiences of HCPs of a father's presence during newborn
38
39 resuscitation.
40
41
42
43

44 45 **METHOD**

46
47
48
49 A qualitative descriptive, retrospective design was utilised using the critical incident
50
51 approach (21).
52
53
54

55 56 **Participants**

1
2
3
4
5 Purposive sampling was utilised to recruit participants from one large teaching
6 hospital in the UK. It was anticipated that 35-40 participants would be required in
7 order to obtain descriptions of a range of scenarios. Therefore recruitment, data
8 collection and data analysis occurred concurrently until data saturation was
9 achieved. The only inclusion criterion was that the HCP had experience of neonatal
10 resuscitation in the delivery room when the baby's father was present. No exclusion
11 criteria were identified. Participants were recruited using a range of strategies:
12 posters inviting HCPs to take part were displayed in various locations within the
13 maternity unit and NNU; HCP meetings were attended to discuss the study and
14 information leaflets were distributed in the delivery suite and NNU. Some participants
15 also recommended other HCPs. In accordance with the critical incident approach
16 (21), recruitment continued until a range of HCPs who had encountered a variety of
17 experiences was recruited (22).
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35

36 Forty-nine HCPs were approached about or volunteered to take part in the study. Six
37 HCPs subsequently decided not to take part (2 midwives and 4 neonatal nurses).
38 Another six said they would participate but staff shortages and workload issues
39 meant that the interview did not take place (2 midwives, 2 neonatal nurses, 1
40 paediatrician and 1 obstetrician). The final sample consisted of 37 HCPs including
41 midwives, obstetricians, anaesthetists, neonatal nurse practitioners, neonatal nurses
42 and paediatricians. The sample included participants with diverse clinical
43 backgrounds and experience (23) (Table 1). The participants were from a range of
44 ethnic backgrounds corresponding to the main groups represented in the study site's
45 local population. Detail regarding the participants' ages and ethnicity have not been
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

1
2
3 included to safeguard participant anonymity. Neonatal nurses were recruited
4
5 because this part of the study also explored HCPs' experiences of the father's first
6
7 visit to his baby on the NNU (not reported here). All the neonatal nurses who
8
9 participated in this phase of the study, regularly attended delivery suite to support
10
11 other staff during newborn resuscitation.
12

13 14 15 16 **INTERVIEWS**

17
18 Semi-structured, qualitative interviews were undertaken using Flanagan's critical
19
20 incident approach (21). Participants were asked to select an incident involving
21
22 newborn resuscitation in the delivery room when they and the baby's father had
23
24 been present. The intention was to explore the HCP's interpretation of the father's
25
26 experience. Participants described what happened and how those present,
27
28 particularly the father, responded (22,24). Some chose to describe incidents that had
29
30 occurred within the previous week, whilst others selected events that had occurred
31
32 several months ago. The interviewer (MH) used key questions and follow-up
33
34 questions to facilitate the description of events and to explore HCP perceptions and
35
36 feelings. The use of the follow-up or probing questions varied according to the
37
38 participant's initial response. In some instances HCPs began by talking about the
39
40 mother or the parents collectively. However, subsequent probing questions
41
42 encouraged them to focus their account on the father. This flexible approach
43
44 enabled HCPs to describe what happened and their feelings in their own words
45
46 (25,26). In order to ensure a range of scenarios were explored, participants were
47
48 asked to describe two contrasting incidents (27,28). The interviews ranged between
49
50 22 and 78 minutes (mean 48 minutes). Participants were interviewed in a private
51
52 room within the Hospital. Most of the interviews took place on weekday afternoons
53
54
55
56
57
58
59
60

1
2
3 within the HCP's working day. With participant informed consent, the interviews were
4
5 tape-recorded to enable verbatim transcription and data analysis. Five HCPs
6
7 (midwives and neonatal nurses) cried as they recalled the resuscitation and on two
8
9 occasions, the recording was temporarily stopped. At the end of the interview, all
10
11 participants were given a debriefing sheet identifying possible sources of support. In
12
13 accordance with qualitative methods; data collection, transcription and data analysis
14
15 were carried out concurrently (26,29). The study was approved by the Solihull Local
16
17 Research Ethics Committee (05/Q2706/104). University and trust approvals were
18
19 also obtained. All participants gave informed consent immediately before the
20
21 interview.
22
23
24
25
26

27 ANALYSIS

28
29
30
31
32 The first author transcribed the interviews and undertook preliminary data analysis.
33
34 The transcriptions were read and reread in order to facilitate understanding.
35
36 Thematic analysis was then undertaken whereby the first transcript was coded into
37
38 themes. Subsequent transcripts were then analysed and additional themes or sub-
39
40 themes were generated when the data captured something new. The software
41
42 package 'NVivo 7' was used to facilitate this process as it enables the researcher to
43
44 identify relationships between the themes (30). During this stage, the development of
45
46 the thematic framework was undertaken in consultation with the second author. Data
47
48 collection continued until no new themes were identified during data analysis (data
49
50 saturation) (25,31). The thematic framework was then reviewed and revised by both
51
52 authors until the final framework was agreed.
53
54
55
56
57
58
59
60

RESULTS

Analysis of the data generated four themes, each of which contained subthemes: 'whose role?' 'saying and doing,' 'teamwork' and 'impact on me.' These themes are described and illustrated with a direct quotation that represents the participants' responses. Whilst the focus of the study was the experiences of fathers, a range of quotes have been utilised to demonstrate the extent to which participants also referred to the parents or the mother.

Whose role?

This theme focuses on whose role it was to support the father during and after the resuscitation. In the events described no-one exclusively took on these roles and no-one was delegated to do so. This was because HCP attention was focused on delivering care to the mother and/or baby (Table 2 – 2.1). Whilst representatives of all HCP groups felt the midwife was the most appropriate person to support and communicate with the father, they acknowledged that she had other responsibilities at the time (Table 2 – 2.2). Verbal communication with the parents during the resuscitation was in most cases directed towards the mother. Participants thought this was appropriate because unlike the father, most mothers could not see what was happening. In addition, HCPs believed that fathers could hear what was being said. Consequently fathers received limited direct information and support and this was generally only given on an 'ad hoc' basis.

1
2
3
4
5 Any information that was given to fathers during the resuscitation was usually
6 provided by an anaesthetist or midwife. This was most commonly general
7 information because they did not feel it was their responsibility to give more detail at
8 this time. On occasions when the resuscitation was prolonged neonatal nurses
9 sometimes described going over to the parents / mother to explain what was
10 happening when the baby's condition had been stabilised (Table 2 – 2.3). Once
11 resuscitation was completed some babies required NNU admission whilst others
12 remained with their parents. Paediatricians, neonatal nurse practitioners and
13 neonatal nurses described speaking to the parents at this time. However, midwives
14 also recalled advocating for parents by prompting paediatricians to speak to parents
15 before they left the delivery room.
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31

32 All HCP groups discussed whether they debriefed the fathers after the resuscitation.
33 Most midwives described attempting to speak to the father by himself to explain what
34 had happened and correct misunderstandings. However, in many instances this was
35 not possible because of other demands or lack of opportunity. Anaesthetists and
36 obstetricians did not feel it was part of their role to debrief fathers and although
37 paediatricians, neonatal nurse practitioners and neonatal nurses recalled instances
38 when they had done this, the discussion was usually initiated by the father days or
39 weeks later, when the baby was being cared for in the NNU. Many of the
40 participants were reluctant to get involved in these discussions particularly neonatal
41 nurses who had been present during the resuscitation (Table 2 – 2.4). They felt
42 uncomfortable discussing events particularly if they thought the father would become
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

1
2
3 distressed. They were also concerned about being asked questions they could not
4
5 answer.

6
7 Almost all participants were aware that other specialties have implemented WR
8
9 strategies to support relatives who are present during the resuscitation of a family
10
11 member. Whilst participants felt that these strategies would be of benefit to fathers,
12
13 they felt these were unlikely to be implemented due to staff shortages and a lack of
14
15 resources (Table 2 – 2.5).
16
17

20 21 **Saying and doing**

22
23 This theme focuses on the HCPs' reflection on factors that influenced what they said
24
25 to fathers and the ways they supported them during and after the resuscitation.
26

27 Anaesthetists and midwives acknowledged that they usually only gave fathers
28
29 general information during the resuscitation because they were uncertain what was
30
31 happening or how the baby was responding. However, they tried to say something
32
33 positive such as commenting on the amount or colour of the baby's hair.
34
35

36
37
38 When paediatricians, neonatal nurse practitioners and neonatal nurses spoke to
39
40 parents after the resuscitation the information given varied, ranging from detailed
41
42 information to a more general summary of events. Needing to get the baby to the
43
44 NNU as quickly as possible appeared to influence the nature and extent of
45
46 information given. Consequently parents whose baby required more extensive
47
48 resuscitation were often given the least amount of information.
49
50

51
52
53
54 Being able to draw on previous experience and background knowledge was felt to be
55
56 invaluable. However, most participants had not received any education or training
57
58
59
60

1
2
3 about communicating with fathers, either generally or in specific situations such as
4
5 newborn resuscitation. HCPs in senior posts also said they did not address these
6
7 issues when teaching juniors (Table 3 – 3.1). Midwives who had trained more
8
9 recently had received some teaching about supporting fathers in general, but this
10
11 was minimal. All HCPs felt their way of supporting and communicating with fathers
12
13 had evolved through experience. Some midwives and anaesthetists felt they had
14
15 become skilled at observing non-verbal cues portrayed by fathers and this enabled
16
17 them to support them more effectively. Other HCPs drew on experience in related
18
19 specialties, taking personal responsibility for their own learning, discussions with
20
21 fathers and reflection on their practice (Table 3 – 3.2).
22
23
24
25
26

27
28 In developing their ways of supporting and communicating with fathers, HCPs said
29
30 they drew on two other elements: observing the practice of others and thinking about
31
32 how they would like to be treated. They described learning from mentors, senior
33
34 colleagues, their peers or junior staff, and recalled both positive and negative
35
36 scenarios (Table 3 – 3.3). Obstetricians often specifically mentioned learning good
37
38 practice from midwives. Several HCPs used the phrase “putting yourself in their
39
40 shoes.” Female HCPs modified this approach to thinking about how they would like
41
42 their partner to be treated (Table 3 – 3.4). Despite the various strategies developed
43
44 over time all HCP groups said they often did not know what to say to fathers during
45
46 prolonged episodes of resuscitation (Table 3 – 3.5).
47
48
49
50

51 **Teamwork**

52
53
54 When thinking about factors that may have impacted on the father’s, participants
55
56 identified the importance of effective teamwork and inter-professional working during
57
58
59
60

1
2
3 the resuscitation. They felt that when the team worked well together, the situation
4
5 was usually dealt with quickly and smoothly to the benefit of all concerned, including
6
7 the father. Senior HCPs described having an 'instinctive' way of working with their
8
9 colleagues such that verbal communication was not required. They described
10
11 scenarios when those present spontaneously took on different roles and
12
13 responsibilities assisting and supporting each other (Table 4 – 4.1). Obstetricians
14
15 and anaesthetists recalled distracting the father so that he could not see what was
16
17 happening and to reduce the risk of him hindering the resuscitation in any way. This
18
19 approach enabled their colleagues to focus on the resuscitation and none of the
20
21 fathers intervened with the resuscitation in the incidents described. Anaesthetists
22
23 also described assisting with the resuscitation, particularly when a junior
24
25 paediatrician was having difficulty intubating the baby. Several midwives described
26
27 responding to a crash call. They often took on the role of 'go-between,' relaying
28
29 information between the neonatal and obstetric teams and the parents. The
30
31 importance of senior HCPs supporting junior staff was also identified (Table 4 – 4.2).
32
33
34
35
36
37

38 **Impact on me**

39
40
41
42
43 Whilst the intention of this study was to explore the HCP's interpretation of the
44
45 father's experience, the HCPs frequently reflected on the impact of the events they
46
47 described on themselves. During the resuscitation, HCPs described trying to adopt a
48
49 calm and self-assured manner regardless of how they were feeling. They hoped this
50
51 attitude would be transmitted to the father and as a consequence, he would be
52
53 comforted and reassured. Many midwives however, said it was difficult to adopt this
54
55 approach and when recounting specific events described them as being "awful",
56
57
58
59
60

1
2
3 “horrendous”, “terrible” and “shocking.” In a less extreme way, when they reflected
4 on specific events, several midwives felt they should have done more to support the
5 father (Table 5 – 5.1).
6
7
8
9

10
11
12 Another issue some paediatricians and the neonatal nurse practitioners talked about
13 was when the father approached the resuscitaire during the resuscitation. The
14 neonatal nurse practitioners and some of the more senior paediatricians were
15 comfortable with this and felt it did not impact on their practice in a negative way
16 (Table 5 – 5.2). Others however, felt uneasy being watched so closely and felt it
17 placed additional stress on them in an already pressurised situation (Table 5 – 5.3).
18
19
20
21
22
23
24
25
26

27
28 The HCPs rarely said the events they described had a positive impact on them. Their
29 relief and satisfaction when all was well was usually implied rather than stated. This
30 may be because in many cases, the busy nature of the care setting meant that they
31 often quickly became involved in the care of other parents and babies with limited
32 opportunity to reflect on what had happened. Midwives were the only HCPs who
33 described becoming emotional when the resuscitation was successful. This is
34 probably because in most cases they had been directly involved in the couple’s care
35 during labour.
36
37
38
39
40
41
42
43
44
45
46

47 **DISCUSSION**

48
49
50
51
52 This is the first known reported study to explore the experiences and perceptions of
53 HCPs involved in neonatal resuscitation in the delivery room when the baby’s father
54 was present. The interviews provide strong evidence of HCPs’ perspectives of this
55
56
57
58
59
60

1
2
3 type of scenario. Although all HCP groups said the fathers needed support and
4 information during the resuscitation, it was acknowledged these needs were almost
5 always unmet. This confirms a finding from an earlier phase of the broader study
6 (12). HCPs felt this was because their priorities at the time were the health of the
7 baby or the mother. A view also shared by fathers in an earlier phase of this study
8 (12). Although HCPs thought the midwife was probably best placed to support the
9 father it was acknowledged that that she had a duty of care to the mother and was
10 often involved in her ongoing care. A key factor in the failure to meet the needs of
11 fathers appeared to be that none of the professional groups involved had direct
12 responsibility to support and communicate with him. It was frequently stated that “he
13 wasn’t my patient” or “that’s not part of my role.”
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

29 Most HCPs were aware that in other care settings a designated HCP often supports
30 relatives when they witness resuscitation events (14,32,33). The role of the
31 chaperone is to explain what is happening and to support, reassure, and de-brief the
32 relative. They can also intervene if the relative’s behaviour becomes distracting
33 (20,32). This role is generally undertaken by a senior HCP, usually a nurse, who can
34 provide appropriate information and support (32). Whilst the HCPs suggested a
35 chaperone would be beneficial for fathers, it was felt staff shortages and lack of
36 resources would prevent this from happening.
37
38
39
40
41
42
43
44
45
46
47
48

49 The HCPs identified a number of factors that could have added to what would have
50 already been a difficult experience for fathers. These factors included a lack of direct
51 information at key points and situations where fathers were excluded or
52 marginalised. Many HCPs also described the impact of events on them and aspects
53
54
55
56
57
58
59
60

1
2
3 they found difficult. An issue that frequently occurred was what to say during
4
5 prolonged resuscitation. Experienced HCPs as well as those who had been working
6
7 in the specialty for a short time identified this difficulty. The more acute distress
8
9 displayed by midwives and neonatal nurses during the interviews was most
10
11 commonly because they felt the situation was not handled well and they felt culpable
12
13 to some extent. Obstetricians, anaesthetists and paediatricians were more 'matter-
14
15 of-fact' about what happened and did not appear to feel responsible when a father's
16
17 needs were not met. However, paediatricians described their discomfort when
18
19 fathers came to the resuscitator. This may indicate a lack of confidence in their ability
20
21 or their recognition that the presence of the father can cause additional pressure at
22
23 an already stressful time. This was explored in the early literature regarding WR in
24
25 other care settings such as adult and paediatric intensive care and accident and
26
27 emergency departments which reports that HCPs felt WR would have a negative
28
29 impact on them (14,17,18). However, over time HCPs who have been exposed to
30
31 WR have found ways to accommodate it in their practice.
32
33
34
35
36
37

38
39 Guidance about supporting parents in the delivery room is given in the recently
40
41 updated European and UK newborn life-support training programmes, mainly in
42
43 relation to communicating with parents before, during and after the event (34,35).
44
45 However, no specific guidance is given about ways to communicate with or ways to
46
47 support the father. This would appear to be an area worthy of development given the
48
49 lack of confidence that some HCPs expressed about communicating with fathers
50
51 during resuscitation events, particularly when the resuscitation was prolonged.
52
53
54

55 56 **STRENGTHS AND LIMITATIONS** 57 58 59 60

1
2
3 The study's strengths and limitations are acknowledged:
4
5
6

- 7
- 8 • The critical incident approach was generally an appropriate way to explore
9 HCPs' experiences of specific events. This approach enabled many of them
10 to consider the impact of newborn resuscitation on fathers for the first time.
11
12
 - 13 • Some participants found focusing on issues pertaining to the father more
14 difficult and sometimes talked about the mother or the parents collectively.
15 However, subsequent probing questions encouraged them to concentrate on
16 the father.
17
18
 - 19 • Some participants chose to describe events that occurred a while ago. It is
20 therefore difficult to determine the extent to which recall bias influenced their
21 descriptions. However, they appeared to have no difficulty remembering their
22 feelings or what happened. They were often surprised at how clearly they
23 could recall the event.
24
25
 - 26 • Incidents where the baby did not survive were not described. HCPs may have
27 thought the researchers were only interested in events where the baby
28 survived, although this was not stated by the interviewer. Alternatively, they
29 may have deliberately elected not to recall an incident that they thought might
30 be too sensitive or potentially controversial to discuss.
31
32
 - 33 • Whilst the preliminary data analysis was undertaken by the first author, the
34 thematic framework was discussed with the second author as it was
35 developed and the final framework was agreed by both authors.
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51

52
53
54 Although undertaken in one setting, the findings from this independent study provide
55 insight to the experiences and perceptions of HCPs and the context in which the
56
57
58
59
60

1
2
3 resuscitation events occurred (25). Given the qualitative nature of this study, it is
4
5 inappropriate to generalize the findings to the wider population. However, in
6
7 accordance with the notion of transferability, the findings of this study have
8
9 highlighted issues that may be of relevance in other settings (23). To gain a broader
10
11 view of HCPs' experiences and the longer term impact, this study could be replicated
12
13 with larger groups of HCPs. It would also be valuable to explore the experiences of
14
15 HCPs where the baby did not survive the resuscitation. Although such a study would
16
17 present challenges, it would have the potential to provide insight to situations that
18
19 could have profound and possibly long lasting effects on HCPs. This in turn could
20
21 influence the provision of HCP education, training and support in the future.
22
23
24
25

26 27 **IMPLICATIONS FOR PRACTICE**

28
29
30
31
32 To some extent newborn resuscitation is part of the normal working day for many
33
34 HCPs involved in perinatal care. However, some midwives and neonatal nurses
35
36 became distressed when discussing events some of which occurred some time ago
37
38 and yet remained a strong memory. This suggests there is a need for greater
39
40 recognition of the impact of resuscitation events on HCPs. The provision of
41
42 opportunities for formal and informal reflection on practice, debriefing and support
43
44 could be more extensive.
45
46
47
48

49
50 The HCPs were generally aware of the needs of fathers during and after newborn
51
52 resuscitation. However, a number of difficulties and challenges affected how they
53
54 supported and communicated with fathers. Whilst there is increasing evidence
55
56 pertaining to the needs of fathers, in maternity care, HCPs generally focus on the
57
58
59
60

1
2
3 needs of mothers and babies (36); duty of care and professional responsibilities
4
5 determine this. Nevertheless, it would appear that there is scope for much more
6
7 extensive HCP education and training about supporting and communicating with
8
9 fathers around the time of newborn resuscitation. The allocation of resources to
10
11 support the provision of a chaperone for fathers during resuscitation would also be
12
13 worthy of consideration by service providers (14,20).
14
15

16 17 18 **ACKNOWLEDGEMENTS**

19
20
21
22
23 We would like to thank the health care professionals who participated in this study
24
25 and were willing to share their experiences so readily.
26
27

28 29 **COMPETING INTERESTS**

30
31
32
33
34 Both authors have completed the Unified Competing Interest form at
35
36 http://www.icmje.org/coi_disclosure.pdf (available on request from the corresponding
37
38 author) and declare: no support from any organisation for the submitted work; no
39
40 financial relationships with any organisations that might have an interest in the
41
42 submitted work in the previous three years, no other relationships or activities that
43
44 could appear to have influenced the submitted work.
45
46
47
48

49 **DATA SHARING**

50
51
52
53
54 No additional data available.
55
56
57
58
59
60

FUNDING

Development and approval of the study, participant recruitment, data collection and initial data analysis were undertaken when the first author held the Bliss Neonatal Nurse Research Fellow post at the National Perinatal Epidemiology Unit, University of Oxford. The first author's PhD fees were met by Birmingham City University and the first author. All other expenses were met by the first author. Aston University was the sponsor. This included providing University approval for the study and ensuring the study was carried out in accordance with the Research Governance Framework.

AUTHORS' CONTRIBUTIONS

Dr M.E Harvey (MH) developed and designed the research proposal, negotiated access to the study-site, obtained the required approvals, recruited participants, conducted the interviews, undertook the data analysis and wrote the first draft of this paper. Professor HM Pattison (HP) supervised MH throughout the study, reviewed and agreed the coding framework, contributed to and has agreed the final version of the paper. MH is the guarantor.

The Corresponding Author has the right to grant on behalf of all authors and does grant on behalf of all authors, an exclusive licence on a worldwide basis to the BMJ Publishing Group Ltd and its Licensees to permit this article (if accepted) to be

1
2
3 published in BMJ editions and any other BMJ PGL products and sub-licences to
4
5 exploit all subsidiary rights, as set out in our licence.
6

7 REFERENCES

- 8
9
10
11 1. World Health Organization. *Fatherhood and Health Outcomes in Europe*.
12 World Health Organization: Copenhagen 2007
13
- 14
15
16
17 2. Klaus MH, Kennell JH. *Parent-Infant Bonding*. Second edition. CV Mosby: St.
18 Louis MO 1982
19
- 20
21
22
23 3. Ramchandani P, Stein A, Evans J, et al. Paternal depression in the postnatal
24 period and child development: a prospective population study *Lancet*.
25 2005;365:2201-2205
26
- 27
28
29
30 4. Department of Health, Department for Education and Skills. *National Service*
31 *Framework for children, young people and maternity services – Maternity*
32 London: Department of Health 2004
33
- 34
35
36
37 5. Burgess A. *Maternal and infant health in the perinatal period: the father's role*
38 The Fatherhood Institute: Abergavenny 2008
39
- 40
41
42
43 6. Shribman S. *Making it Better: For Mother and Baby* Department of Health:
44 London 2007
45
- 46
47
48
49 7. Kiernan K, Smith K. Unmarried Parenthood: New Insights from the Millennium
50 Cohort Study. *Popul Trends*. 2003;26-33
51
- 52
53
54
55 8. TNS System Three. *NHS Maternity Services Quantitative Research*.
56 Edinburgh: TNS System Three 2005;44-57
57
58
59
60

- 1
2
3 9. Murthy V, Rao N, Fox GF, et al. Survey of UK newborn resuscitation
4
5 practices. *Arch Dis Child Fetal Neonatal Ed.* 2012;97:F154-5
6
7
- 8
9
10 10. Fulbrook P, Latour JM, Albarra, JW. Paediatric critical care nurses' attitudes
11
12 and experiences of parental presence during cardiorespiratory resuscitation:
13
14 A European survey. *Int J Nurs Stud.* 2007;44:1238-1249
15
16
- 17
18 11. Perry SE. Support for parents witnessing resuscitation: nurse perspectives.
19
20
21 *Paed Nurs.* 2009;21:26-31
22
23
- 24
25 12. Harvey ME, Pattison HM, Being there: a qualitative interview study with
26
27 fathers present during the resuscitation of their baby at delivery. *Arch Dis*
28
29 *Child Fetal Neonatal Ed.* 2012;97:F439-F443
30
31
- 32
33 13. Sacchetti A, Carraccio C, Leva E, et al. Acceptance of family member
34
35 presence during pediatric resuscitations in the emergency department: Effects
36
37 of personal experience. *Pediatr Emerg Care.* 2000; 16:85-87
38
39
- 40
41 14. Grice AS, Picton P, Deakin CDS. Study examining attitudes of staff,
42
43 paediatrics and relatives to witnessed resuscitation in adult intensive care
44
45 units. *Br J Anaesth.* 2003;91:820-824
46
47
48
- 49
50 15. Fulbrook P, Albarran JW, Latour JM. A European survey of critical care
51
52 nurses' attitudes and experiences of having family members present during
53
54 cardiorespiratory resuscitation *Int J Nurs Stud.* 2005;42:557-568
55
56
57
58
59
60

- 1
2
3
4
5 16. McGahey PR. Family presence during pediatric resuscitation: focus on staff
6
7 *Critic Care Nurs.* 2002;22:29-34
8
9
10
11
12 17. Schilling RJ. Should relatives watch resuscitation? – No room for spectators
13
14 *BMJ.* 1994;309:406
15
16
17
18 18. MacLean SL, Guzzetta CE, White C, et al. Family presence during
19
20 cardiopulmonary resuscitation and invasive procedures: practices of critical
21
22 care and emergency nurses *Am J Crit Care.* 2003;12:246- 257
23
24
25
26
27 19. American Academy of Pediatrics. Family-Centred Care and the Pediatricians
28
29 Role *Pediatrics.* 2003;112:691-696
30
31
32
33
34 20. Baskett PJF, Steen PA, Bossaert L. European Resuscitation Council
35
36 Guidelines for Resuscitation 2005 - Section 8. The ethics of resuscitation and
37
38 end-of-life decisions *Resuscitation.* 2005;67:S171-S180
39
40
41
42 21. Flanagan JC. The critical interview technique *Psychology Bulletin.*
43
44 1954;51:327-358
45
46
47
48 22. Broström A, Strömberg A, Dahlström U, et al. Congestive heart failure,
49
50 spouses' support and the couple's sleep situation: a critical incident technique
51
52 analysis *J Clin Nurs.* 2003;12: 223-233
53
54
55
56
57
58
59
60

- 1
2
3 23. O'Leary Z. *The Essential Guide to Doing Research*. London: Sage
4
5 Publications 2004
6
7
8
9
10 24. Sharoff L. Critique of the critical incident technique *J Res Nurs*. 2008;13:301-
11
12 309
13
14
15
16 25. Pope C, Campbell R. Qualitative research in obstetrics and gynaecology. *Brit*
17
18 *J Obstet Gynaec*. 2001;108:233-237
19
20
21
22
23 26. Kvale S, Brinkmann S. *Interviews: Learning the Craft of Qualitative Research*
24
25 *Interviewing*. Second edition. Los Angeles: Sage 2009
26
27
28
29
30
31 27. Robson C. *Real world research*. Third edition. Oxford: Blackwell Publishing
32
33 2012
34
35
36
37
38 28. Silvester J. Work and Organizational Psychology in Willig C, Stainton-Rogers
39
40 W. *The Sage Handbook of Qualitative Research in Psychology*. London:
41
42 Sage Publications 2008
43
44
45 29. Pope C, Ziebland S, Mays N. Analysing qualitative data. *BMJ*. 2000;320:114-
46
47 116
48
49
50 30. Lewins A, Silver C. *Using software in qualitative research*. London: Sage
51
52 Publications 2007
53
54
55
56
57
58
59
60

- 1
2
3 31. Malterud K. Qualitative research: standards, challenges and guidelines.
4
5 *Lancet*. 2001;358:483-488
6
7
8
9
10 32. Goldstein A, Berry K, Callaghan A. Resuscitation witnessed by relatives has
11
12 proved acceptable to doctors in paediatric cases. *BMJ*. 1997;314:144-145
13
14
15
16 33. Robinson SM, Mackenzie-Ross S, Campbell Hewson GL, et al. Psychological
17
18 effect of witnessed resuscitation on bereaved relatives. *Lancet*.
19
20 1998;352:614-617
21
22
23
24
25 34. Nolan JP, Soar J, Zideman DA, et al European Resuscitation Council
26
27 Guidelines for Resuscitation 2010 Section1. Executive summary.
28
29 *Resuscitation*. 2010;81:1219-1276
30
31
32
33
34 35. Resuscitation Council. *Resuscitation at birth*. Third edition. London:
35
36 Resuscitation Council (UK) 2011
37
38
39
40
41 36. McVeigh CA, Baafi M, Williamson M. Functional status after fatherhood: An
42
43 Australian study. *J Obstet Gynecol Neonatal Nurs*. 2002;31:165-171
44
45
46
47
48
49
50
51

HCP Group	No.	Sex	Time from initial qualification	Length of time in current post

Midwives	12	Female*	1 – 29 years	6 months – 5 years
Neonatal nurses	10	Female*	2 – 32 years	6 months – 23 years
Neonatal nurse practitioners	2	Female*	7 – 19 years	6 months – 7 years
Obstetricians	3	Female	9 – 22 years	1 – 6 years
Anaesthetists	4	2 Female 2 Male	6 – 16 years	1 – 6 years
Paediatrician	6	1 Female 5 male	2 – 33 years	2½ months – 18 years

*No males were employed in this role during the period of recruitment

Table 1 Participant biographical details

Table 2 Whose role?

2.1 *“My main focus is the mother. I think that’s, I think it’s important to understand that because the mother’s my patient, the father’s not my*

patient.” (Anaesthetist14)

2.2 *“When the baby was born and she needed resuscitating, he ran out the room crying. I felt like I should have ran after him really which I couldn’t at the time because I was trying to like stop her ((the mother)) from bleeding. So it was difficult but I did think, oh my God.” (Midwife9)*

2.3 *“I at that time, I could not speak to dad because we, our priority was the baby and baby needed intubating. Once that was done I was able to then go and speak to mum just to give her brief information of what was going on, how the baby was.” (NeonatalNurse1)*

2.4 *“It’s not my place, just in case he asked me sensitive questions that I’m not able to answer. It’s very difficult in that situation especially if you’ve got a very sick baby. I would not take part in that at all.” (NeonatalNurse5)*

2.5 *“There’s no-one specifically to do that, unless we employed an extra member of staff just to look after the father, but we can’t do that.” (Anaesthetist13)*

Table 3 **Saying and doing**

3.1 *“I don’t think it’s anything that anybody’s spoken about and I suppose I don’t really speak to the trainees who come through about it either.”*

-
- 1
2
3 (Paediatrician16)
4
5
6 3.2 *"I think my practice is probably based on what I've heard husbands and*
7 *partners tell me and how they felt."* (Midwife15)
8
9
10
11 3.3 *"I have a series of horror stories of observing my consultant teachers in*
12 *days of yore making a complete and utter hash of it. And I use that you*
13 *know and I just, you just learn by thinking, right, if I live a thousand*
14 *years, I will never do that."* (Paediatrician15)
15
16
17
18
19 3.4 *"I always say, speak to people how you would want to be spoken to.*
20 *Treat them the way you want to be treated and just put yourself in their*
21 *situation. You know, it's your partner, that's your baby and somebody's*
22 *not even acknowledging that you're there, how would that make you*
23 *feel?"* (Obstetrician61)
24
25
26
27
28
29 3.5 *"It was awful. No-one was saying anything and mum was crying. I was*
30 *just thinking please, please somebody say something."*
31
32 (NeonatalNurse7)
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
-

54 **Table 4 Teamwork**

-
- 56 4.1 *"If I'm happy the mother's suturing is done and mum's not bleeding,*
57
58
59
60

1
2
3 *mum's fine and everybody is working on the baby then I will stay and*
4 *do whatever I can whether it's fetching for the paediatrician or whether*
5 *it's staying and supporting mum and dad because the midwife's*
6 *helping the paediatrician." (Obstetrician10)*
7
8
9

10
11 4.2 *"It's like yesterday the shoulder dystocia, the baby needed to be*
12 *resuscitated. Me and the Shift Leader talked about it, like you know,*
13 *you go over it like, oh that was awful and, oh he ((the father)) was*
14 *crying, oh it was terrible and you just talk about it and then that helps*
15 *you to kind of deal with what's happened." (Midwife9)*
16
17
18
19
20

21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54 **Table 5** **Impact on me**

55
56 5.1 *"You try and support the fathers and meet their needs when it*
57
58
59
60

1
2
3 *happens. I do have days where I go home deflated thinking I really*
4 *wish I could have done more for him that day.” (Midwife12)*
5
6

7
8 5.2 *“I don’t mind it at all. I’m used to people watching what I do and I think*
9 *he needs to see anyway.” (NeonatalNursePractitioner14)*
10

11
12
13 5.3 *“I don’t like it. Not because it’s a worry to me it’s just because I don’t*
14 *happen to like being watched when I’m working.” (Paediatrician7)*
15

16
17
18 5.4 *“Yes. Even now, after all this time, there are some difficult deliveries*
19 *and you want to, you share in all of that emotion and it’s very easy to*
20 *kind of get prickly eyes when the baby is ok.” (Midwife7)*
21
22
23

1
2
3
4
5
6
7 **The impact of a father's presence during newborn resuscitation: a qualitative**
8 **interview study with health care professionals**
9

10
11
12
13
14 Meryll E Harvey, Helen M Pattison
15

16
17
18
19
20 Meryll E Harvey senior academic Faculty of Health, Birmingham City University,
21 Birmingham B15 3TN Helen M Pattison professor School of Life Health Sciences,
22 Aston University B4 7ET
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50

51 Correspondence to: Dr Meryll E Harvey meryll.harvey@bcu.ac.uk
52
53
54
55
56
57
58
59
60

1
2
3
4
5
6
7 **Objective:** To explore health care professionals' experiences around the time of
8 newborn resuscitation in the delivery room, when the baby's father was present.

Comment [M1]: R2 – reworded to more accurately reflect purpose of study

9
10 **Design:** A qualitative descriptive, retrospective design using the critical incident
11 approach. Tape-recorded semi-structured interviews were undertaken with health
12 care professionals involved in newborn resuscitation. Participants recalled
13 resuscitation events when the baby's father was present. They described what
14 happened and how those present, including the father, responded. They also
15 reflected upon the impact of the resuscitation and the father's presence on
16 themselves. Participant responses were analysed using thematic analysis.

Comment [M2]: R2 - added

17
18
19
20
21
22 **Setting:** A large teaching hospital in the UK.

Comment [M3]: R2 – deleted from results section and added here

23
24 **Participants:** Purposive sampling was utilised. It was anticipated that 35-40

Comment [M4]: R2 – information regarding participants moved to next section

25
26
27
28
29
30
31
32 participants would be recruited. Forty-nine potential participants were invited to take
33 part. The final sample consisted of 37 participants including midwives, obstetricians,
34 anaesthetists, neonatal nurse practitioners, neonatal nurses and paediatricians.

Comment [M5]: R1 - Information added regarding anticipated / final sample size

35
36
37
38 **Results:** Four themes were identified: 'whose role?' 'saying and doing' 'teamwork'
39 and 'impact on me'. Whilst no-one was delegated to support the father during the
40 resuscitation, midwives and anaesthetists most commonly took on this role.

41
42
43
44
45
46
47
48
49
50 Participants felt the midwife was the most appropriate person support fathers. All
51 health care professional groups said they often did not know what to say to fathers
52 during prolonged resuscitation. Teamwork was felt to be of benefit to all concerned,
53 including the father. Some paediatricians described their discomfort when fathers
54 came to the resuscitaire. None of the participants had received education and
55 training specifically on supporting fathers during newborn resuscitation.

56
57
58
59
60 **Conclusions** This is the first known study to specifically explore the experiences of
health care professionals of the father's presence during newborn resuscitation. The

1
2
3
4
5
6
7 findings suggest the need for more focused training about supporting fathers. There
8
9 is also scope for service providers to consider ways in which fathers can be
10 supported more readily during newborn resuscitation.
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

For peer review only

ARTICLE SUMMARY

Article Focus:

The research question for this study was; 'What are the experiences of health care professionals of the father's presence during newborn resuscitation in the delivery room?' To address this question, the objectives of this phase of the study were:

1. To conduct interviews utilising the critical incident approach with HCPs who had experience of newborn resuscitation when the baby's father was present.
2. To provide an account of the experiences of HCPs of newborn resuscitation when the baby's father was present.

Key messages:

The key messages and significance of the study are:

1. Whilst the health care professionals were aware of the information and support needs of fathers during newborn resuscitation, they acknowledged that these needs were rarely met.
2. The health care professionals in this study had not received education and training specifically about supporting fathers during newborn resuscitation.
3. The health care professionals in this study did not utilize strategies to support fathers that are recommended when relatives are present during resuscitation events in other critical care settings.

Strengths and limitations:

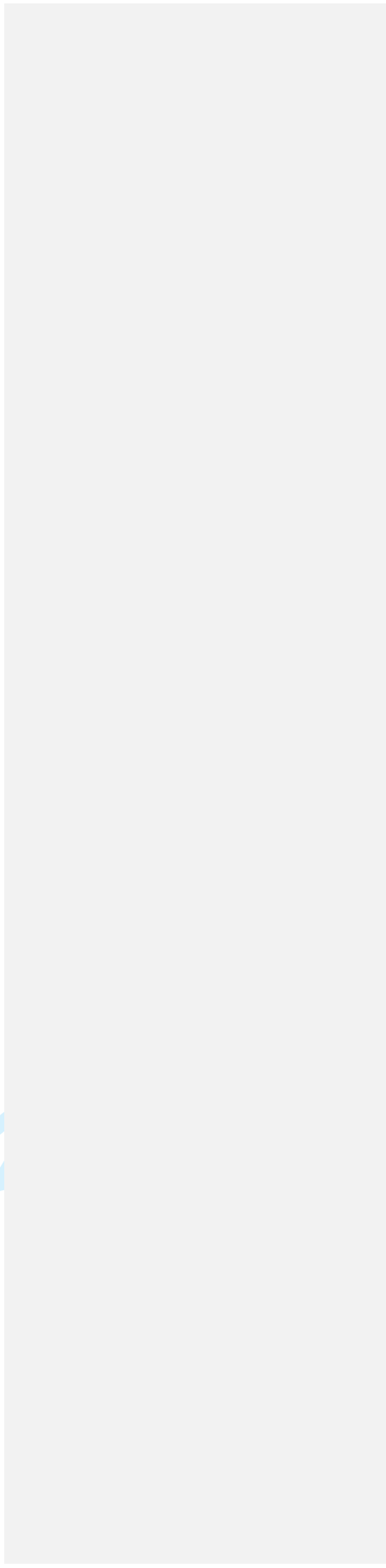
Comment [M6]: Section amended to correlate with strengths and limitations section in main paper

- Although undertaken in one setting, the findings from this independent study provide insight to the experiences and perceptions of HCPs and the context in which the resuscitation events occurred
- The critical incident approach was generally an appropriate way to explore HCPs' experiences of specific events. This approach enabled many of them to consider the impact of newborn resuscitation on fathers for the first time.
- Some participants found focusing on issues pertaining to the father more difficult and sometimes talked about the mother or the parents collectively. However, subsequent probing questions encouraged them to concentrate on the father.
- Some participants chose to describe events that occurred a while ago. It is therefore difficult to determine the extent to which recall bias influenced their descriptions. However, they appeared to have no difficulty remembering their feelings or what happened. They were often surprised at how clearly they could recall the event.
- Incidents where the baby did not survive were not described. HCPs may have thought the researchers were only interested in events where the baby survived, although this was not stated by the interviewer. Alternatively, they may have deliberately elected not to recall an incident that they thought might be too sensitive or potentially controversial to discuss.
- Whilst the preliminary data analysis was undertaken by the first author, the thematic framework was discussed with the second author as it was developed and the final framework was agreed by both authors.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

- Given the qualitative nature of this study, it is inappropriate to generalize the findings to the wider population. However, in accordance with the notion of transferability, the findings of this study have highlighted issues that may be of relevance in other settings.

For peer review only



INTRODUCTION

The birth of their child is often a landmark event for a father and can be an important episode in the on-going process of adaptation to parenthood. Short and more longer term benefits of a father's involvement in the life of his child have been described which can impact on the father, his partner, his baby and society more generally (1,2,3). As a consequence there has been a drive in the UK over the last 10 years to engage and involve fathers more readily, particularly during the perinatal period and during childbirth specifically (4,5,6). However, in order to ensure that fathers are appropriately supported during the perinatal period, it is important that health care professionals (HCPs) have insight to fathers' experiences and needs.

Whilst for the majority of men childbirth is straightforward, for others it is not.

When a newborn baby requires resuscitation in UK settings, the father will usually be present because most fathers attend the birth of their baby and delivery and resuscitation generally take place in the same room (7,8,9). Whilst some studies have investigated the impact on HCPs of parental presence during neonatal resuscitation in the neonatal unit (NNU) (10,11); the father's presence during newborn resuscitation in the delivery room has only been reported in terms of the impact on the father (12).

The experiences of HCPs of the presence of a relative during the resuscitation of a family member has been investigated in settings such as adult and paediatric intensive care and accident and emergency (13,14,15). Early 'witnessed resuscitation' (WR) research identified that many HCPs were not supportive of this approach (16). They were concerned that relatives would be unduly distressed or

Comment [M7]: R2 - Introduction amended and references added

Comment [M8]: R2 - clarification re: HCPs negative view of witnessed resuscitation

1
2
3
4
5
6
7 would be at risk of physical harm due to the nature of the environment. HCPs also
8 felt WR would impinge on themselves and their practice in a negative way
9 (14,17,18). However, despite some initial opposition, most HCPs now embrace the
10 concept of WR and it has become accepted practice in many Western countries over
11 the last two decades. This reflects a generally more open and inclusive approach to
12 health care and recognition of the need to deliver family-centred care (19,20).
13
14
15
16
17
18
19

20 The feelings and perceptions of HCPs' experiences and perceptions of the father's
21 presence during newborn resuscitation in the delivery room do not appear to have
22 been previously investigated. The aim of this part of a wider study (12) was to gain a
23 broader understanding of fathers' experiences through HCPs' accounts of episodes
24 of care. Participants also reflected on the ways in which the father's presence
25 impacted on themselves and their practice. This paper focuses on the findings
26 pertaining to the experiences of HCPs of a father's presence during newborn
27 resuscitation.
28
29
30
31
32
33
34
35
36
37

38 METHOD

39
40
41 A qualitative descriptive, retrospective design was utilised using the critical incident
42 approach (21).
43
44
45

46 Participants

47
48
49 Purposive sampling was utilised to recruit participants from one large teaching
50 hospital in the UK. It was anticipated that 35-40 participants would be required in
51
52
53
54
55
56
57
58
59
60

Comment [M9]: R2 – statement reworded

Comment [M10]: R2 – rationale for study

Comment [M11]: R1 – to clarify referring to individual fathers

Comment [M12]: R2 – sentence added

Comment [M13]: R1 – reference added

1
2
3
4
5
6
7 order to obtain descriptions of a range of scenarios. Therefore recruitment, data
8
9 collection and data analysis occurred concurrently until data saturation was
10
11 achieved. The only inclusion criterion was that the HCP had experience of neonatal
12
13 resuscitation in the delivery room when the baby's father was present. No exclusion
14
15 criteria were identified. Participants were recruited using a range of strategies:
16
17 posters inviting HCPs to take part were displayed in various locations within the
18
19 maternity unit and NNU; HCP meetings were attended to discuss the study and
20
21 information leaflets were distributed in the delivery suite and NNU. Some participants
22
23 also recommended other HCPs. In accordance with the critical incident approach
24
25 (21), recruitment continued until a range of HCPs who had encountered a variety of
26
27 experiences was recruited (22).

28
29
30 Forty-nine HCPs were approached about or volunteered to take part in the study. Six
31
32 HCPs subsequently decided not to take part (2 midwives and 4 neonatal nurses).
33
34 Another six said they would participate but staff shortages and workload issues
35
36 meant that the interview did not take place (2 midwives, 2 neonatal nurses, 1
37
38 paediatrician and 1 obstetrician). The final sample consisted of 37 HCPs including
39
40 midwives, obstetricians, anaesthetists, neonatal nurse practitioners, neonatal nurses
41
42 and paediatricians. The sample included participants with diverse clinical
43
44 backgrounds and experience (23) (Table 1). The participants were from a range of
45
46 ethnic backgrounds corresponding to the main groups represented in the study site's
47
48 local population. Detail regarding the participants' ages and ethnicity have not been
49
50 included to safeguard participant anonymity. Neonatal nurses were recruited
51
52 because this part of the study also explored HCPs' experiences of the father's first
53
54 visit to his baby on the NNU (not reported here). All the neonatal nurses who
55
56
57
58
59
60

Comment [M14]: (& subsequent two comments) R1 – re: why 37 participants

Comment [M15]: R1 – clarification regarding number of participants approached and final number of participants

Comment [M16]: (& previous two comments) R1 – re: why 37 participants

Comment [M17]: R2 – asked for information about age and ethnicity of participants. We have reviewed the various ways this could be done but feel all would risk identification of participants – so this information has not been included as stated here

1
2
3
4
5
6
7 participated in this phase of the study, regularly attended delivery suite to support
8 other staff during newborn resuscitation.
9

10 INTERVIEWS

11
12
13
14 Semi-structured, qualitative interviews were undertaken using Flanagan's critical
15 incident approach (21). Participants were asked to select an incident involving
16 newborn resuscitation in the delivery room when they and the baby's father had
17 been present. The intention was to explore the HCP's interpretation of the father's
18 experience. Participants described what happened and how those present,
19 particularly the father, responded (22,24). Some chose to describe incidents that had
20 occurred within the previous week, whilst others selected events that had occurred
21 several months ago. The interviewer (MH) used key questions and follow-up
22 questions to facilitate the description of events and to explore HCP perceptions and
23 feelings. The use of the follow-up or probing questions varied according to the
24 participant's initial response. In some instances HCPs began by talking about the
25 mother or the parents collectively. However, subsequent probing questions
26 encouraged them to focus their account on the father. This flexible approach
27 enabled HCPs to describe what happened and their feelings in their own words
28 (25,26). In order to ensure a range of scenarios were explored, participants were
29 asked to describe two contrasting incidents (27,28). The interviews ranged between
30 22 and 78 minutes (mean 48 minutes). Participants were interviewed in a private
31 room within the Hospital. Most of the interviews took place on weekday afternoons
32 within the HCP's working day. With participant informed consent, the interviews were
33 tape-recorded to enable verbatim transcription and data analysis. Five HCPs
34 (midwives and neonatal nurses) cried as they recalled the resuscitation and on two
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Comment [M18]: R2 – clarification of critical incident approach used

Comment [M19]: R2 – clarifying purpose of study

Comment [M20]: R2 – clarification re: time lapse between incident and interview

Comment [M21]: R2 – explanation added re: use of probing questions.

Comment [M22]: R2 – clarification of the number of incidents described

Comment [M23]: R2 – moved from results section

1
2
3
4
5
6 occasions, the recording was temporarily stopped. At the end of the interview, all
7
8 participants were given a debriefing sheet identifying possible sources of support. In
9
10 accordance with qualitative methods; data collection, transcription and data analysis
11
12 were carried out concurrently (26,29). The study was approved by the Solihull Local
13
14 Research Ethics Committee (05/Q2706/104). University and trust approvals were
15
16 also obtained. All participants gave informed consent immediately before the
17
18 interview.
19

20 21 22 ANALYSIS

Comment [M24]: R1 and R2 – clarification re:
data analysis process

23
24
25
26 The first author transcribed the interviews and undertook preliminary data analysis.

27
28 The transcriptions were read and reread in order to facilitate understanding.

29
30 Thematic analysis was then undertaken whereby the first transcript was coded into

31
32 themes. Subsequent transcripts were then analysed and additional themes or sub-

33
34 themes were generated when the data captured something new. The software

35
36 package 'NVivo 7' was used to facilitate this process as it enables the researcher to

37
38 identify relationships between the themes (30). During this stage, the development of

39
40 the thematic framework was undertaken in consultation with the second author. Data

41
42 collection continued until no new themes were identified during data analysis (data

43
44 saturation) (25,31). The thematic framework was then reviewed and revised by both

45
46 authors until the final framework was agreed.
47
48
49
50
51
52
53
54
55
56
57
58
59
60

RESULTS

Analysis of the data generated four themes, each of which contained subthemes: 'whose role?' 'saying and doing,' 'teamwork' and 'impact on me.' These themes are described and illustrated with a direct quotation that represents the participants' responses. Whilst the focus of the study was the experiences of fathers, a range of quotes have been utilised to demonstrate the extent to which participants also referred to the parents or the mother.

Comment [M25]: R2 – acknowledgement of sub-themes. Number deliberately not stated

Comment [M26]: R2 – the quotes used throughout are representative of the responses of participants in relation to that particular theme

Comment [M27]: R2- clarification re: fathers / parents / mothers

Whose role?

This theme focuses on whose role it was to support the father during and after the resuscitation. In the events described no-one exclusively took on these roles and no-one was delegated to do so. This was because HCP attention was focused on delivering care to the mother and/or baby (Table 2 – 2.1). Whilst representatives of all HCP groups felt the midwife was the most appropriate person to support and communicate with the father, they acknowledged that she had other responsibilities at the time (Table 2 – 2.2). Verbal communication with the parents during the resuscitation was in most cases directed towards the mother. Participants thought this was appropriate because unlike the father, most mothers could not see what was happening. In addition, HCPs believed that fathers could hear what was being said. Consequently fathers received limited direct information and support and this was generally only given on an 'ad hoc' basis.

Comment [M28]: R2 – explanation of theme

Comment [M29]: R2 - clarification

Comment [M30]: R2 - added

Comment [M31]: R2 – re: number of occasions communication directed to mother

1
2
3
4
5
6
7 Any information that was given to fathers during the resuscitation was usually
8 provided by an anaesthetist or midwife. This was most commonly general
9 information because they did not feel it was their responsibility to give more detail at
10 this time. On occasions when the resuscitation was prolonged neonatal nurses
11 sometimes described going over to the parents / mother to explain what was
12 happening when the baby's condition had been stabilised (Table 2 – 2.3). Once
13 resuscitation was completed some babies required NNU admission whilst others
14 remained with their parents. Paediatricians, neonatal nurse practitioners and
15 neonatal nurses described speaking to the parents at this time. However, midwives
16 also recalled advocating for parents by prompting paediatricians to speak to parents
17 before they left the delivery room.
18
19
20
21
22
23
24
25
26
27

Comment [M32]: R2 – clarification re: quote used

28
29
30 All HCP groups discussed whether they debriefed the fathers after the resuscitation.
31 Most midwives described attempting to speak to the father by himself to explain what
32 had happened and correct misunderstandings. However, in many instances this was
33 not possible because of other demands or lack of opportunity. Anaesthetists and
34 obstetricians did not feel it was part of their role to debrief fathers and although
35 paediatricians, neonatal nurse practitioners and neonatal nurses recalled instances
36 when they had done this, the discussion was usually initiated by the father days or
37 weeks later, when the baby was being cared for in the NNU. Many of the
38 participants were reluctant to get involved in these discussions particularly neonatal
39 nurses who had been present during the resuscitation (Table 2 – 2.4). They felt
40 uncomfortable discussing events particularly if they thought the father would become
41 distressed. They were also concerned about being asked questions they could not
42 answer.
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Comment [M33]: R2 - added

Comment [M34]: R2 – clarification re: reluctance to debrief fathers

1
2
3
4
5
6
7 Almost all participants were aware that other specialties have implemented WR
8 strategies to support relatives who are present during the resuscitation of a family
9 member. Whilst participants felt that these strategies would be of benefit to fathers,
10 they felt these were unlikely to be implemented due to staff shortages and a lack of
11 resources (Table 2 – 2.5).
12
13
14
15
16
17

Comment [M35]: R2 – paragraph and new quote added to support issue raised in discussion

18 Saying and doing

Comment [M36]: R2 – clarification re: theme

19
20 This theme focuses on the HCPs' reflection on factors that influenced what they said
21 to fathers and the ways they supported them during and after the resuscitation.
22
23

24 Anaesthetists and midwives acknowledged that they usually only gave fathers
25 general information during the resuscitation because they were uncertain what was
26 happening or how the baby was responding. However, they tried to say something
27 positive such as commenting on the amount or colour of the baby's hair.
28
29
30
31

32
33 When paediatricians, neonatal nurse practitioners and neonatal nurses spoke to
34 parents after the resuscitation the information given varied, ranging from detailed
35 information to a more general summary of events. Needing to get the baby to the
36 NNU as quickly as possible appeared to influence the nature and extent of
37 information given. Consequently parents whose baby required more extensive
38 resuscitation were often given the least amount of information.
39
40
41
42
43
44
45

46
47 Being able to draw on previous experience and background knowledge was felt to be
48 invaluable. However, most participants had not received any education or training
49 about communicating with fathers, either generally or in specific situations such as
50 newborn resuscitation. HCPs in senior posts also said they did not address these
51
52
53
54

Comment [M37]: R2 – clarification re: senior HCPs

1
2
3
4
5
6
7 **issues when teaching juniors** (Table 3 – 3.1). Midwives who had trained more
8 recently had received some teaching about supporting fathers in general, but this
9 was minimal. All HCPs felt their way of supporting and communicating with fathers
10 had evolved through experience. Some midwives and anaesthetists felt they had
11 become skilled at observing non-verbal cues portrayed by fathers and this enabled
12 them to support them more effectively. Other HCPs drew on experience in related
13 specialties, taking personal responsibility for their own learning, discussions with
14 fathers and reflection on their practice (Table 3 – 3.2).

15
16
17
18
19
20
21
22
23
24 In developing their ways of supporting and communicating with fathers, HCPs said
25 they drew on two other elements: observing the practice of others and thinking about
26 how they would like to be treated. They described learning from mentors, senior
27 colleagues, their peers or junior staff, and recalled both positive and negative
28 scenarios (Table 3 – 3.3). Obstetricians often specifically mentioned learning good
29 practice from midwives. Several HCPs used the phrase “putting yourself in their
30 shoes.” Female HCPs modified this approach to thinking about how they would like
31 their partner to be treated (Table 3 – 3.4). Despite the various strategies developed
32 over time all HCP groups said they often did not know what to say to fathers during
33 prolonged episodes of resuscitation (Table 3 – 3.5).

34 35 36 37 38 39 40 41 42 43 44 **Teamwork**

45
46
47 **When thinking about factors that may have impacted on the father’s, participants**
48 **identified the importance of effective teamwork and inter-professional working during**
49 **the resuscitation.** They felt that when the team worked well together, the situation
50 was usually dealt with quickly and smoothly to the benefit of all concerned, including
51
52
53
54
55
56
57
58
59
60

Comment [M38]: R2 – clarification re: theme

1
2
3
4
5
6
7 the father. Senior HCPs described having an 'instinctive' way of working with their
8 colleagues such that verbal communication was not required. They described
9 scenarios when those present spontaneously took on different roles and
10 responsibilities assisting and supporting each other (Table 4 – 4.1). **Obstetricians**
11 **and anaesthetists recalled distracting the father so that he could not see what was**
12 **happening and to reduce the risk of him hindering the resuscitation in any way. This**
13 **approach enabled their colleagues to focus on the resuscitation and none of the**
14 **fathers intervened with the resuscitation in the incidents described.** Anaesthetists
15 also described assisting with the resuscitation, particularly when a junior
16 paediatrician was having difficulty intubating the baby. Several midwives described
17 responding to a crash call. They often took on the role of 'go-between,' relaying
18 information between the neonatal and obstetric teams and the parents. The
19 importance of senior HCPs supporting junior staff was also identified (Table 4 – 4.2).

32 33 **Impact on me**

34
35
36
37 **Whilst the intention of this study was to explore the HCP's interpretation of the**
38 **father's experience, the HCPs frequently reflected on the impact of the events they**
39 **described on themselves.** During the resuscitation, HCPs described trying to adopt a
40 calm and self-assured manner regardless of how they were feeling. They hoped this
41 attitude would be transmitted to the father and as a consequence, he would be
42 comforted and reassured. Many midwives however, said it was difficult to adopt this
43 approach and when recounting specific events described them as being "awful",
44 "horrendous", "terrible" and "shocking." In a less extreme way, when they reflected
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Comment [M39]: R2 – explanation re: distraction

Comment [M40]: R2 – explanation re: theme

1
2
3
4
5
6
7 on specific events, several midwives felt they should have done more to support the
8 father (Table 5 – 5.1).
9

10
11
12 Another issue some paediatricians and the neonatal nurse practitioners talked about
13 was when the father approached the resuscitator during the resuscitation. The
14 neonatal nurse practitioners and some of the more senior paediatricians were
15 comfortable with this and felt it did not impact on their practice in a negative way
16 (Table 5 – 5.2). Others however, felt uneasy being watched so closely and felt it
17 placed additional stress on them in an already pressurised situation (Table 5 – 5.3).
18
19
20
21
22
23
24
25

26 The HCPs rarely said the events they described had a positive impact on them. Their
27 relief and satisfaction when all was well was usually implied rather than stated. This
28 may be because in many cases, the busy nature of the care setting meant that they
29 often quickly became involved in the care of other parents and babies with limited
30 opportunity to reflect on what had happened. Midwives were the only HCPs who
31 described becoming emotional when the resuscitation was successful. This is
32 probably because in most cases they had been directly involved in the couple's care
33 during labour.
34
35
36
37
38
39
40
41
42

43 **DISCUSSION**

44
45
46 This is the first known reported study to explore the experiences and perceptions of
47 HCPs involved in neonatal resuscitation in the delivery room when the baby's father
48 was present. The interviews provide strong evidence of HCPs' perspectives of this
49 type of scenario. Although all HCP groups said the fathers needed support and
50
51
52
53
54
55
56
57
58
59
60

1
2
3
4
5
6
7 information during the resuscitation, it was acknowledged these needs were almost
8 always unmet. This confirms a finding from an earlier phase of the broader study
9
10 (12). HCPs felt this was because their priorities at the time were the health of the
11 baby or the mother. A view also shared by fathers in an earlier phase of this study
12
13 (12). Although HCPs thought the midwife was probably best placed to support the
14 father it was acknowledged that that she had a duty of care to the mother and was
15
16 often involved in her ongoing care. A key factor in the failure to meet the needs of
17
18 fathers appeared to be that none of the professional groups involved had direct
19
20 responsibility to support and communicate with him. It was frequently stated that “he
21
22 wasn’t my patient” or “that’s not part of my role.”
23
24
25
26
27

28 Most HCPs were aware that in other care settings a designated HCP often supports
29
30 relatives when they witness resuscitation events (14,32,33). The role of the
31
32 chaperone is to explain what is happening and to support, reassure, and de-brief the
33
34 relative. They can also intervene if the relative’s behaviour becomes distracting
35
36 (20,32). This role is generally undertaken by a senior HCP, usually a nurse, who can
37
38 provide appropriate information and support (32). Whilst the HCPs suggested a
39
40 chaperone would be beneficial for fathers, it was felt staff shortages and lack of
41
42 resources would prevent this from happening.
43
44

45 The HCPs identified a number of factors that could have added to what would have
46
47 already been a difficult experience for fathers. These factors included a lack of direct
48
49 information at key points and situations where fathers were excluded or
50
51 marginalised. Many HCPs also described the impact of events on them and aspects
52
53 they found difficult. An issue that frequently occurred was what to say during
54
55
56
57
58
59
60

Comment [M41]: R2 – clarification regarding previous publication. This was in relation to the first phase of the study which involved interviews with fathers

1
2
3
4
5
6
7 prolonged resuscitation. Experienced HCPs as well as those who had been working
8 in the specialty for a short time identified this difficulty. The more acute distress
9 displayed by midwives and neonatal nurses during the interviews was most
10 commonly because they felt the situation was not handled well and they felt culpable
11 to some extent. Obstetricians, anaesthetists and paediatricians were more 'matter-
12 of-fact' about what happened and did not appear to feel responsible when a father's
13 needs were not met. However, paediatricians described their discomfort when
14 fathers came to the resuscitaire. This may indicate a lack of confidence in their ability
15 or their recognition that the presence of the father can cause additional pressure at
16 an already stressful time. This was explored in the early literature regarding WR in
17 other care settings such as adult and paediatric intensive care and accident and
18 emergency departments which reports that HCPs felt WR would have a negative
19 impact on them (14,17,18). However, over time HCPs who have been exposed to
20 WR have found ways to accommodate it in their practice.
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50

51
52
53
54
55
56
57
58
59
60

Guidance about supporting parents in the delivery room is given in the recently updated European and UK newborn life-support training programmes, mainly in relation to communicating with parents before, during and after the event (34,35). However, no specific guidance is given about ways to communicate with or ways to support the father. This would appear to be an area worthy of development given the lack of confidence that some HCPs expressed about communicating with fathers during resuscitation events, particularly when the resuscitation was prolonged.

STRENGTHS AND LIMITATIONS

The study's strengths and limitations are acknowledged:

Comment [M42]: R2 – clarification re: care settings

Comment [M43]: Section amended in response to R1 comments. Bullet points added and limitations acknowledged

- 1
2
3
4
5
6
7
8
9 • The critical incident approach was generally an appropriate way to explore
10 HCPs' experiences of specific events. This approach enabled many of them
11 to consider the impact of newborn resuscitation on fathers for the first time.
12
13
14 • Some participants found focusing on issues pertaining to the father more
15 difficult and sometimes talked about the mother or the parents collectively.
16 However, subsequent probing questions encouraged them to concentrate on
17 the father.
18
19
20
21
22 • Some participants chose to describe events that occurred a while ago. It is
23 therefore difficult to determine the extent to which recall bias influenced their
24 descriptions. However, they appeared to have no difficulty remembering their
25 feelings or what happened. They were often surprised at how clearly they
26 could recall the event.
27
28
29
30
31
32 • Incidents where the baby did not survive were not described. HCPs may have
33 thought the researchers were only interested in events where the baby
34 survived, although this was not stated by the interviewer. Alternatively, they
35 may have deliberately elected not to recall an incident that they thought might
36 be too sensitive or potentially controversial to discuss.
37
38
39
40
41
42 • Whilst the preliminary data analysis was undertaken by the first author, the
43 thematic framework was discussed with the second author as it was
44 developed and the final framework was agreed by both authors.
45
46
47

48
49 Although undertaken in one setting, the findings from this independent study provide
50 insight to the experiences and perceptions of HCPs and the context in which the
51 resuscitation events occurred (25). Given the qualitative nature of this study, it is
52
53
54

Comment [M44]: R1 – potential recall bias acknowledged

Comment [M45]: R1 – clarification re: data analysis process

Comment [M46]: R1 – clarification re: potential transferability of findings

1
2
3
4
5
6 inappropriate to generalize the findings to the wider population. However, in
7
8 accordance with the notion of transferability, the findings of this study have
9
10 highlighted issues that may be of relevance in other settings (23). To gain a broader
11
12 view of HCPs' experiences and the longer term impact, this study could be replicated
13
14 with larger groups of HCPs. It would also be valuable to explore the experiences of
15
16 HCPs where the baby did not survive the resuscitation. Although such a study would
17
18 present challenges, it would have the potential to provide insight to situations that
19
20 could have profound and possibly long lasting effects on HCPs. This in turn could
21
22 influence the provision of HCP education, training and support in the future.
23
24

25 26 **IMPLICATIONS FOR PRACTICE**

27
28
29 To some extent newborn resuscitation is part of the normal working day for many
30
31 HCPs involved in perinatal care. However, some midwives and neonatal nurses
32
33 became distressed when discussing events some of which occurred some time ago
34
35 and yet remained a strong memory. This suggests there is a need for greater
36
37 recognition of the impact of resuscitation events on HCPs. The provision of
38
39 opportunities for formal and informal reflection on practice, debriefing and support
40
41 could be more extensive.
42
43
44

45 The HCPs were generally aware of the needs of fathers during and after newborn
46
47 resuscitation. However, a number of difficulties and challenges affected how they
48
49 supported and communicated with fathers. Whilst there is increasing evidence
50
51 pertaining to the needs of fathers, in maternity care, HCPs generally focus on the
52
53 needs of mothers and babies (36); duty of care and professional responsibilities
54
55
56
57
58
59
60

1
2
3
4
5
6
7 determine this. Nevertheless, it would appear that there is scope for much more
8 extensive HCP education and training about supporting and communicating with
9 fathers around the time of newborn resuscitation. The allocation of resources to
10 support the provision of a chaperone for fathers during resuscitation would also be
11 worthy of consideration by service providers (14,20).
12
13
14
15
16

17 18 **ACKNOWLEDGEMENTS**

19
20
21 We would like to thank the health care professionals who participated in this study
22 and were willing to share their experiences so readily.
23
24
25
26

27 28 **COMPETING INTERESTS**

29
30
31 Both authors have completed the Unified Competing Interest form at
32 http://www.icmje.org/coi_disclosure.pdf (available on request from the corresponding
33 author) and declare: no support from any organisation for the submitted work; no
34 financial relationships with any organisations that might have an interest in the
35 submitted work in the previous three years, no other relationships or activities that
36 could appear to have influenced the submitted work.
37
38
39
40
41
42
43

44 45 **DATA SHARING**

46
47
48 **No additional data available.**
49
50
51
52
53
54
55
56
57
58
59
60

FUNDING

Development and approval of the study, participant recruitment, data collection and initial data analysis were undertaken when the first author held the Bliss Neonatal Nurse Research Fellow post at the National Perinatal Epidemiology Unit, University of Oxford. The first author's PhD fees were met by Birmingham City University and the first author. All other expenses were met by the first author. Aston University was the sponsor. This included providing University approval for the study and ensuring the study was carried out in accordance with the Research Governance Framework.

AUTHORS' CONTRIBUTIONS

Dr M.E Harvey (MH) developed and designed the research proposal, negotiated access to the study-site, obtained the required approvals, recruited participants, conducted the interviews, undertook the data analysis and wrote the first draft of this paper. Professor HM Pattison (HP) supervised MH throughout the study, reviewed and agreed the coding framework, contributed to and has agreed the final version of the paper. MH is the guarantor.

The Corresponding Author has the right to grant on behalf of all authors and does grant on behalf of all authors, an exclusive licence on a worldwide basis to the BMJ Publishing Group Ltd and its Licensees to permit this article (if accepted) to be published in BMJ editions and any other BMJ PGL products and sub-licences to exploit all subsidiary rights, as set out in our licence.

REFERENCES

Comment [M47]: First 6 references added to support amended introduction

1. World Health Organization. *Fatherhood and Health Outcomes in Europe*. World Health Organization: Copenhagen 2007
2. Klaus MH, Kennell JH. *Parent-Infant Bonding*. Second edition. CV Mosby: St. Louis MO 1982
3. Ramchandani P, Stein A, Evans J, O'Connor TG and the ALSPAC study team. Paternal depression in the postnatal period and child development: a prospective population study *Lancet*. 2005;365:2201-2205
4. Department of Health, Department for Education and Skills. *National Service Framework for children, young people and maternity services – Maternity* London: Department of Health 2004
5. Burgess A. *Maternal and infant health in the perinatal period: the father's role* The Fatherhood Institute: Abergavenny 2008
6. Shribman S. *Making it Better: For Mother and Baby* Department of Health: London 2007
7. Kiernan K, Smith K. Unmarried Parenthood: New Insights from the Millennium Cohort Study. *Popul Trends*. 2003;26-33
8. TNS System Three. *NHS Maternity Services Quantitative Research*. Edinburgh: TNS System Three 2005;44-57

- 1
2
3
4
5
6
7 9. Murthy V, Rao N, Fox GF, Milner AD, Campbell M, Greenough A. Survey of
8 UK newborn resuscitation practices. *Arch Dis Child Fetal Neonatal Ed.*
9 2012;97:F154-5
10
11
12
13
14 10. Fulbrook P, Latour JM, Albarra, JW. Paediatric critical care nurses' attitudes
15 and experiences of parental presence during cardiorespiratory resuscitation:
16 A European survey. *Int J Nurs Stud.* 2007;44:1238-1249
17
18
19
20
21
22 11. Perry SE. Support for parents witnessing resuscitation: nurse perspectives.
23 *Paed Nurs.* 2009;21:26-31
24
25
26
27
28 12. Harvey ME, Pattison HM, Being there: a qualitative interview study with
29 fathers present during the resuscitation of their baby at delivery. *Arch Dis*
30 *Child Fetal Neonatal Ed.* 2012;97:F439-F443
31
32
33
34
35
36 13. Sacchetti A, Carraccio C, Leva E, Harris RH, Lichenstein R. Acceptance of
37 family member presence during pediatric resuscitations in the emergency
38 department: Effects of personal experience. *Pediatr Emerg Care.* 2000;
39 16:85-87
40
41
42
43
44
45 14. Grice AS, Picton P, Deakin CDS. Study examining attitudes of staff,
46 paediatrics and relatives to witnessed resuscitation in adult intensive care
47 units. *Br J Anaesth.* 2003;91:820-824
48
49
50
51
52
53
54
55
56
57
58
59
60

- 1
2
3
4
5
6
7 15. Fulbrook P, Albarran JW, Latour JM. A European survey of critical care
8 nurses' attitudes and experiences of having family members present during
9 cardiorespiratory resuscitation *Int J Nurs Stud.* 2005;42:557-568
10
11
12
13
14 16. McGahey PR. Family presence during pediatric resuscitation: focus on staff
15 *Critic Care Nurs.* 2002;22:29-34
16
17
18
19
20 17. Schilling RJ. Should relatives watch resuscitation? – No room for spectators
21 *BMJ.* 1994;309:406
22
23
24
25
26 18. MacLean SL, Guzzetta CE, White C, Fontaine D, Eichhorn DJ, Meyers TA et
27 al. Family presence during cardiopulmonary resuscitation and invasive
28 procedures: practices of critical care and emergency nurses *Am J Crit Care.*
29 2003;12:246- 257
30
31
32
33
34
35 19. American Academy of Pediatrics. Family-Centred Care and the Pediatricians
36 Role *Pediatrics.* 2003;112:691-696
37
38
39
40
41 20. Baskett PJF, Steen PA, Bossaert L. European Resuscitation Council
42 Guidelines for Resuscitation 2005 - Section 8. The ethics of resuscitation and
43 end-of-life decisions *Resuscitation.* 2005;67:S171-S180
44
45
46
47
48 21. Flanagan JC. The critical interview technique *Psychology Bulletin.*
49 1954;51:327-358
50
51
52
53
54
55
56
57
58
59
60

- 1
2
3
4
5
6
7 22. Broström A, Strömberg A, Dahlström U, Fridlund B. Congestive heart failure,
8 spouses' support and the couple's sleep situation: a critical incident technique
9 analysis *J Clin Nurs*. 2003;12: 223-233
10
11
12
13
14 23. O'Leary Z. *The Essential Guide to Doing Research*. London: Sage
15 Publications 2004
16
17
18
19
20 24. Sharoff L. Critique of the critical incident technique *J Res Nurs*. 2008;13:301-
21 309
22
23
24
25
26 25. Pope C, Campbell R. Qualitative research in obstetrics and gynaecology. *Brit*
27 *J Obstet Gynaec*. 2001;108:233-237
28
29
30
31 26. Kvale S, Brinkmann S. *Interviews: Learning the Craft of Qualitative Research*
32 *Interviewing*. Second edition. Los Angeles: Sage 2009
33
34
35
36
37
38 27. Robson C. *Real world research*. Third edition. Oxford: Blackwell Publishing
39 2012
40
41
42
43
44 28. Silvester J. Work and Organizational Psychology in Willig C, Stainton-Rogers
45 *W. The Sage Handbook of Qualitative Research in Psychology*. London:
46 Sage Publications 2008
47
48
49
50 29. Pope C, Ziebland S, Mays N. Analysing qualitative data. *BMJ*. 2000;320:114-
51 116
52
53
54
55
56
57
58
59
60

- 1
2
3
4
5
6
7 30. Lewins A, Silver C. *Using software in qualitative research*. London: Sage
8 Publications 2007
9
10
11
12 31. Malterud K. Qualitative research: standards, challenges and guidelines.
13
14 *Lancet*. 2001;358:483-488
15
16
17
18 32. Goldstein A, Berry K, Callaghan A. Resuscitation witnessed by relatives has
19
20 proved acceptable to doctors in paediatric cases. *BMJ*. 1997;314:144-145
21
22
23
24 33. Robinson SM, Mackenzie-Ross S, Campbell Hewson GL, Egleston CV,
25
26 Prevost AT. Psychological effect of witnessed resuscitation on bereaved
27
28 relatives. *Lancet*. 1998;352:614-617
29
30
31
32 34. Nolan JP, Soar J, Zideman DA, *et al* European Resuscitation Council
33
34 Guidelines for Resuscitation 2010 Section 1. Executive summary.
35
36 *Resuscitation*. 2010;81:1219-1276
37
38
39 35. Resuscitation Council. *Resuscitation at birth*. Third edition. London:
40
41 Resuscitation Council (UK) 2011
42
43
44
45 36. McVeigh CA, Baafi M, Williamson M. Functional status after fatherhood: An
46
47 Australian study. *J Obstet Gynecol Neonatal Nurs*. 2002;31:165-171
48
49
50
51
52
53
54
55
56
57
58
59
60

HCP Group	No.	Sex	Time from initial qualification	Length of time in current post
Midwives	12	Female*	1 – 29 years	6 months – 5 years
Neonatal nurses	10	Female*	2 – 32 years	6 months – 23 years
Neonatal nurse practitioners	2	Female*	7 – 19 years	6 months – 7 years
Obstetricians	3	Female	9 – 22 years	1 – 6 years
Anaesthetists	4	2 Female 2 Male	6 – 16 years	1 – 6 years
Paediatrician	6	1 Female 5 male	2 – 33 years	2½ months – 18 years

*No males were employed in this role during the period of recruitment

Table 1 Participant biographical details

Table 2 Whose role?

2.1	<i>"My main focus is the mother. I think that's, I think it's important to understand that because the mother's my patient, the father's not my patient."</i> (Anaesthetist14)
2.2	<i>"When the baby was born and she needed resuscitating, he ran out the room crying. I felt like I should have ran after him really which I couldn't at the time because I was trying to like stop her ((the mother)) from bleeding. So it was difficult but I did think, oh my God."</i> (Midwife9)
2.3	<i>"I at that time, I could not speak to dad because we, our priority was the baby and baby needed intubating. Once that was done I was able to then go and speak to mum just to give her brief information of what was going on, how the baby was."</i> (NeonatalNurse1)
2.4	<i>"It's not my place, just in case he asked me sensitive questions that I'm not able to answer. It's very difficult in that situation especially if you've got a very sick baby. I would not take part in that at all."</i> (NeonatalNurse5)
2.5	<i>"There's no-one specifically to do that, unless we employed an extra member of staff just to look after the father, but we can't do that."</i> (Anaesthetist13)

Comment [M48]: Added to support additional material in relation to this theme

Table 3 **Saying and doing**

- 3.1 *"I don't think it's anything that anybody's spoken about and I suppose I don't really speak to the trainees who come through about it either."*
(Paediatrician16)
- 3.2 *"I think my practice is probably based on what I've heard husbands and partners tell me and how they felt."* (Midwife15)
- 3.3 *"I have a series of horror stories of observing my consultant teachers in days of yore making a complete and utter hash of it. And I use that you know and I just, you just learn by thinking, right, if I live a thousand years, I will never do that."* (Paediatrician15)
- 3.4 *"I always say, speak to people how you would want to be spoken to. Treat them the way you want to be treated and just put yourself in their situation. You know, it's your partner, that's your baby and somebody's not even acknowledging that you're there, how would that make you feel?"* (Obstetrician61)
- 3.5 *"It was awful. No-one was saying anything and mum was crying. I was just thinking please, please somebody say something."*
(NeonatalNurse7)
-

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Table 4 **Teamwork**

- 4.1 *"If I'm happy the mother's suturing is done and mum's not bleeding, mum's fine and everybody is working on the baby then I will stay and do whatever I can whether it's fetching for the paediatrician or whether it's staying and supporting mum and dad because the midwife's helping the paediatrician."* (Obstetrician10)
- 4.2 *"It's like yesterday the shoulder dystocia, the baby needed to be resuscitated. Me and the Shift Leader talked about it, like you know, you go over it like, oh that was awful and, oh he ((the father)) was crying, oh it was terrible and you just talk about it and then that helps you to kind of deal with what's happened."* (Midwife9)
-

Table 5 **Impact on me**

- 5.1 *"You try and support the fathers and meet their needs when it happens. I do have days where I go home deflated thinking I really wish I could have done more for him that day."* (Midwife12)
- 5.2 *"I don't mind it at all. I'm used to people watching what I do and I think he needs to see anyway."* (NeonatalNursePractitioner14)
- 5.3 *"I don't like it. Not because it's a worry to me it's just because I don't happen to like being watched when I'm working."* (Paediatrician7)
- 5.4 *"Yes. Even now, after all this time, there are some difficult deliveries and you want to, you share in all of that emotion and it's very easy to kind of get prickly eyes when the baby is ok."* (Midwife7)
-

1
2
3
4
5 Interview schedule
6

7 Opening statement: **This interview forms part of a larger study that aims to gain an**
8 **understanding of the experiences and perceptions of fathers who attend the birth of**
9 **their baby, especially when the baby has required resuscitation at birth and / or**
10 **admission to a neonatal unit.**

11
12 **Within this interview I am particularly interested in your experience of situations when**
13 **a sick / preterm baby is delivered, requires resuscitation at birth and / or admission to**
14 **a neonatal unit, and the baby's father is present. Before consideration of key issues,**
15 **can I clarify the following?**
16

17
18 **Job title / Qualifications / Length of time qualified / Length of time this post**
19

20 KEY ISSUES TO EXPLORE
21

22 **There are a variety of situations that you might have experienced:**
23

- 24 **▪ The antenatal preparation of fathers (i.e. before labour has started) particularly**
25 **if the birth of a sick / preterm baby is anticipated.**
- 26 **▪ Being at the delivery of a sick / preterm baby when the baby's father is also**
27 **present.**
- 28 **▪ Being at the resuscitation of a newborn baby when the baby's father is also**
29 **present.**
- 30 **▪ Being present when a baby is admitted to the neonatal unit when the baby's**
31 **father is also present.**
32

33
34 **Which of the above do you have experience of?**
35

36 **When was the last time that you encountered each situation?**
37

38 *(check each individual situation)*
39

40 **So, for the purpose of this interview we'll be talking about you**

- 41 **▪ *Being involved in the antenatal preparation of fathers (i.e. before labour has started)***
42 ***particularly if the birth of a sick / preterm baby is anticipated.***
- 43 **▪ *Being at the delivery of a sick / preterm baby when the baby's father is also present.***
- 44 **▪ *Being at the resuscitation of a newborn baby when the baby's father is also present.***
- 45 **▪ *Being present when a baby is admitted to the neonatal unit when the baby's father is***
46 ***also present.***
47

48 **Can you recall an occasion you were involved with relating to**
49

50 *Follow up any specific information to clarify description of events.*

51 *Clarify participant's role in the situation – what did you do / say?*

52 *Why does this case particularly spring to mind?*
53

54 **Is there anything that you'd like to add, particularly regarding what happened to the**
55 **father?**

56 *Follow up any specific information to clarify description of events.*

57 *Clarify participant's role in the situation – what did you do / say?*

58 *Do you know if the father wanted to be there?*
59

60 **Thinking back to that occasion, do you think that the situation went well or not as well**
as it could have done?

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Why do you think this was the case?

What about the father in this case? – looking at it from his perspective – did it go well or not as well as it could have done?

Why do you think this was the case?

Can you recall a contrasting situation you were involved with, by that I mean one that didn't / did go well?– can you tell me about that?

Follow up any specific information to clarify description of events.

Clarify details / participant's role in the situation – what did you do / say?

What do you think were the key issues that made this situation different to the previous case?

Why does this case particularly spring to mind?

Is there anything that you'd like to add, particularly regarding what happened to the father?

Follow up any specific information to clarify description of events.

Clarify participant's role in the situation – what did you do / say?

From his perspective do you think that he'd say it went well or not as well as it could have done?

Clarify participant's role in the situation – what did you do / say?

What do you suppose fathers feel that they need in terms of information / support antenatally / prior to the delivery / resuscitation / admission of their baby?

On what basis do you say this?

In your experience, do you think this happens in reality?

Why does / doesn't this happen?

What do think are the issues that a health care professional should consider when supporting a father at this time?

Do you think that different fathers have different needs? – if so – how do you determine individual needs?

Which health care professional group do you think has ultimate responsibility for supporting fathers at this time?

What do you suppose fathers feel that they need in terms of information / support during the delivery / resuscitation / admission of their baby?

On what basis do you say this?

In your experience, do you think this happens in reality?

Why does / doesn't this happen?

What do you think are the issues that a health care professional should consider when supporting a father at this time?

Do you think that different fathers have different needs? – if so – how do you determine individual needs?

How do you determine if the father wants to be there?

Which health care professional group do you think has ultimate responsibility for supporting fathers at this time?

What do you suppose fathers feel that they need in terms of information / support after the delivery / resuscitation / admission of their baby?

On what basis do you say this?

What impact do you think being present at..... has on fathers?

In your experience, do you think this happens in reality?

Why does / doesn't this happen?

What do you think are the issues that a health care professional should consider when supporting a father at this time?

1
2
3 Do you think that different fathers have different needs? – if so – how do you determine
4 individual needs?

5 Which health care professional group do you think has ultimate responsibility for supporting
6 fathers at this time?
7

8
9 **Can you tell me about the nature / extent of any educational preparation you've
10 received regarding the provision of support specifically for fathers during delivery /
11 resuscitation / admission to the neonatal unit?**

12 Clarify details.

13 Have you participated in 'mock' incidents? For example: labour ward drill?).

14 Was it father / mother / parent focused?

15 Has this been adequate?

16 If no how do you now know what to do / say in these situations? What additional educational
17 preparation do you feel you need?

18 Apart from more formal educational preparation, how else have you learned what to do / say
19 in these situations?
20

21
22 **We've talked quite a lot about the health care professional role when supporting
23 fathers – I'd like now to ask you to think about the impact that carrying out this role
24 has on you – can you tell me about that?**

25 Positive / negative impact – particularly re: helping / supporting fathers.

26 Short & long-term effects.

27 Is this always the case or just sometimes?

28 If sometimes – what key factors trigger this effect on you?

29 Re: negative effects – how do you deal / cope with this?

30 In these situations is there anything that fathers could do to help you?
31

32
33 **Do you have any suggestions about ways that hospitals / health care professionals
34 could help fathers who experience the situations we've discussed?**

35 Follow-up any specific issues that might have been raised earlier.

36 Does the hospital have policies / procedures / guidelines re: supporting / care of fathers? – if
37 yes – clarify details – if not – why not? – do you think that there should be policies /
38 procedures / guidelines in place?

39 What advice would you give to another health care professional who might be about to
40 support a father in one of these situations for the first time?
41

42 **Are there any other issues that you would like to raise in relation to these issues?**

43
44 **Can I end by asking some more information about yourself?**

45 Age / How would you describe your ethnicity /
46
47
48

49 **Thank-you very much for your help with this part of the study.**
50
51
52
53
54
55
56
57
58
59
60