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The Effect of Fathers Upon Direct Nursing Care of Labor Patients

Mary M. Kline
University of Colorado Boulder

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THE EFFECT OF FATHERS UPON DIRECT NURSING CARE OF LABOR PATIENTS

by

Mary M. Kline

Diploma, Presbyterian Hospital School of Nursing,

Denver, 1947

B.S., University of Denver, 1954

A Thesis submitted to the Faculty of the Graduate School of the University of Colorado in partial fulfillment of the requirements for the Degree Master of Science

School of Nursing

1960
This Thesis for the M. S. Degree by

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has been approved for the

School of Nursing

by

Date May 9, 1960
The Effect of Fathers Upon Direct Nursing Care of Labor Patients
Thesis directed by Assistant Professor Betty L. Highley

The purpose of this thesis was to observe, time, and compare direct nursing care given to primiparous patients in the labor rooms when the fathers were present or absent, to determine if the father's presence had any significant effect upon the amount of direct nursing care given.

An observation guide and recording sheet were devised to collect data regarding the amount of nursing time consumed in five areas of direct intrapartum nursing care. The observations were done in the labor corridors of two private hospitals. Sixteen patients were observed for nursing care, eight with the father present, eight without.

Analysis of the data obtained revealed a decrease of 33 per cent in the amount of direct nursing care when the father was present. There was a decrease in all five areas of direct nursing care. Evidence obtained also indicated a possible relationship between the presence of the father and the length of labor. The hypothesis that there would be no significant difference in the total amount of direct nursing care whether the father was present in or absent from the labor room was nullified.

Recommendations were made that parents be permitted to be together during labor when they wish, that hospitals reexamine policies concerning fathers in the labor rooms, that students be assigned to labor patients when the father is present, and that studies be done concerning the quality of nursing care and the effect upon the length of labor when the father is present in the labor room.
This abstract of about 250 words is approved as to form and content.

I recommend its publication.

Signed

Instructor in charge of thesis
ACKNOWLEDGMENTS

The writer wishes to express sincere appreciation to Assistant Professor Betty L. Highley and Professor Katherine Kelly who contributed untiring support, guidance, and encouragement in the planning and writing of this thesis. Special thanks is extended to Associate Professor Robert L. Gasser for his counsel and additional assistance in working the statistical Chi-Square, and to Fern Hildenbrandt, Director of Nursing Service at Presbyterian Hospital for her timely suggestions.

Grateful appreciation is also extended to the administrative staffs and labor room staffs of the two hospitals where the study was conducted, for without their interest and wholehearted cooperation the study would not have been possible.
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CHAPTER I

THE PROBLEM INTRODUCED

The modern nurse is living in a time of change and progress in maternity care. Feelings of security have been found to increase when the parents have been permitted to be together during one of the most important moments of their married life, the birth experience. More and more hospitals have become aware of the need to include the father as a part of the maternity team. There has been resistance to change in the management of the labor patient, from both doctors and nurses, in spite of the results of studies which have shown emotional benefit to both parents when they could be together during labor.

I. NEED FOR THE STUDY

The problem of the separation of a family during specific medical and surgical experiences has been discussed at length in recent nursing and medical journals. Emphasis has been placed upon the importance of care of the "whole" person in sickness or health. Mental health in pregnancy, and emotional support during labor and the puerperium have been stressed in the past decade, especially in the obstetric nursing textbooks. "Rooming-In," and more liberal visiting periods have come

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into focus, and in a few hospitals, the father has been allowed to be in the labor rooms.\textsuperscript{3} Nurses were reminded that having a baby involved every member of the family, yet the security of the family continued to be threatened at a critical time, in many hospitals.

Many parents want to be instructed about the process of pregnancy and childbirth, together. They also want to be together in labor, for they feel the need for each other's support, and find it unnatural to be separated during the birth of their child.\textsuperscript{4} Questions have been raised concerning the possibility of additional demands upon the busy labor-room nurses when the father is present. Since no report was found of a study concerning nursing care given in the labor rooms when the father was present or absent, it seemed that such a study would be indicated.

II. THE PROBLEM

Statement of the problem. Does the presence of the father in the labor room during labor have any effect upon the amount of direct nursing care given to the labor patient? What area of nursing is influenced most, and to what extent? Is more or less nursing time needed to care for the labor patient when the father is permitted to be with her throughout her labor room experience?

Purpose of the study. It was the purpose of this study to observe and time nursing care given to labor patients in the labor room when the father was present, and when the father was not present, and compare data.


\textsuperscript{4}DeClue, \textit{loc. cit.}
It was believed the findings would prove useful in (1) providing data which would help some hospitals take a more analytical view in determining if fathers should be permitted in their labor rooms; (2) teaching student nurses the importance of family-centered nursing care in the labor rooms; (3) orienting new nurses to the maternity services, especially the labor corridors; and (4) planning In-Service Education. The findings of this study should also be of interest to nurses who have definite feelings either way concerning the advisability of permitting the fathers in the labor rooms.

The hypothesis to be tested. The hypothesis to be tested in this study was that there would be no significant difference in the total amount of direct nursing care given to the labor patient whether the father was present in or absent from the labor room. It was believed there might be some difference in the amount of nursing care in given areas of nursing care, but the final total would be approximately the same.

Scope and limitations of the study. The desires of some parents concerning being together during labor, and the emotional benefits to mother and father, have been studied and the findings reported in several books and nursing or medical journals. This study was confined to the problem of analyzing time spent in direct nursing care of labor patients when the fathers were present and when they were absent. Five general areas of direct nursing care were studied and total time consumed was compared.

Sixteen married primiparous patients were chosen for observation of nursing care. Eight were taken from each of two private hospitals in the city of Denver. Both hospitals permitted the father in the labor room at certain times.
One person did a non-participant observation, which made it impossible to observe for prolonged periods of time. Six hours was set as the limit.

A quantitative study of nursing care was done rather than a qualitative study. The study did not attempt to show the quality of nursing care when fathers were present or absent from the labor rooms.

Uncontrollable variables which were recognized as having possible influence upon the course of labor were (1) temperament of either parent, (2) educational background of either parent, (3) instruction from well-meaning family and friends, (4) preparation for labor in classes or in the doctor's office, (5) age, (6) cultural and religious influence, (7) individual pain levels, and (8) biological factors related to child-bearing.

III. DEFINITIONS OF TERMS USED

The following definitions were accepted for this study:

1. **Mother.** The patient in labor.

2. **Father.** The husband of the labor patient and father of the unborn child.

3. **Direct nursing care.** All nursing activities carried out at the bedside of the patient for her well-being.5

4. **Family-centered nursing care.** Nursing care which takes into consideration the needs of the mother, the father, and the child in the family unit.

---

Ernestine Wiedenbach has stated that:

Family-centered maternity nursing has as its primary purpose not only the maximum safety, health and welfare of each mother and expected baby, but also enhancement of the childbearing experience to the greatest degree possible for each mother, father and child. ... It is directed always toward strengthening parents' inner resources so that they may be better able to participate in the mother's pregnancy, labor and delivery, and to experience deep and enduring satisfactions which may be reflected throughout the childbearing period as well as in their role as parents.  

---

6 Wiedenbach, op. cit., p. 1.
CHAPTER II

AN HISTORICAL REVIEW OF THE FATHER’S ROLE IN PARTURITION

A review of literature revealed a dearth of reported studies concerning the role of the father in childbirth. However, a few recent books and articles touched briefly on past and present customs.

I. ANCIENT CUSTOMS

Early man is believed to have been his wife’s only assistant at birth.\(^1\) About the time historical records were first kept, he was permitted to ask another woman to assist him in difficult labors, and later in any labor.\(^2\) Special women were appointed by the tribes to attend women in labor. In some tribes, she was the mother or mother-in-law of the mother in labor. In others, a certain woman was appointed to attend all of the women. She was often known as the midwife. At first, this midwife was untrained, but later a certain type of training was required, in some cultures beginning with the experience of bearing her own child.\(^3\)


\(^3\) Dill, loc. cit.
Soon after the advent of the midwife, in some cultures the father was "excluded from the lying-in chamber, not to be readmitted for many centuries." In other cultures the father continued to take an active part in parturition. In Greece, during the days of Hippocrates, the husband played an important supporting role during labor and delivery. In Hungary, for centuries, the peasant father has helped in prolonged or difficult labor. This custom is still practiced there. In China for many centuries, the father supported the mother on the side of the bed while the baby was being born.

In the European countries at the onset of the Renaissance, it was a crime worthy of death for a man other than the father to attend a mother in childbirth, and the father was not encouraged to be present except in difficult labor.

As can be noted from these brief reports, the practice of excluding the father from the lying-in rooms has never been universal. Leo Simmons stated that:

We moderns are about the only people on earth who prescribe for the father an idle, nervous, inconsequential role in this critical period. Our culture can really make a father feel quite silly on the occasion of the birth of his offspring.

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4 Ibid.
5 Graham, op. cit., pp. 54-55.
6 Ibid., p. 4.
8 Dill, op. cit., p. 6.
II. CURRENT PRACTICES AMONG PRIMITIVE TRIBES

The father plays an important part in labor in many cultures and tribes. Sometimes they are at the bedside of the mother, other times they are busy elsewhere. When a baby of the Seriono tribe of Bolivia is preparing to emerge into the family, the father immediately sets out on a hunt. If he bags his game he will give a good name to the child. When he returns, he cuts the cord, then retires to his hammock where he observes a three-day couvade, or male childbirth. The mother stays in her own hammock except to care for the child. On the third day the parents take the placenta and other waste into the forest to conclude the birth rituals.10

In Brazil, the father stays with the mother in labor. She squats on the ground and he squats directly behind her and presses down on her abdomen, with the contractions, in an effort to help push the baby out. When the child is born, the father ties and cuts the cord. The Malayans and Polynesians observe similar customs.11

In the Umatjera tribe of North Australia, the mother sits on the father's lap for labor and delivery. As soon as she becomes pregnant he begins to prepare her for delivery by rubbing her abdomen with oil and singing ritualistic songs. In the Dutch East Indies, the father sits on the ground and holds the mother between his legs until the baby is born.12

10 Simmons, loc. cit.
11 Graham, op. cit., pp. 3-4.
12 Ibid.
The Laplanders and American Indians of certain areas, among whom are the Arapahoe, work together throughout the pregnancy for the good of the unborn child. Details concerning parturition were not found.

III. THE FATHER'S CHANGING ROLE IN THE AMERICAN CULTURE

The American father has not always paced the hospital corridors or waited anxiously in the "fathers" room while his baby was being born. Forty years ago and earlier, it was virtually impossible to persuade a respectable mother of moderate income to go to a hospital for a normal delivery. Only mothers with severe complications, or the destitute or derelict women sought hospitalization for labor and delivery. Until the turn of the century, the few maternity hospitals or wards were near medical schools or midwifery schools and were used for instruction. No record could be found of the father being permitted in these hospitals. It is quite unlikely, as the wards were often open and large, and medical or nursing students were there. The fathers' presence would have been embarrassing to all. As recently as 1935, only 36.9 per cent of the mothers delivered in hospitals. In 1954, the number had increased to 93.6 per cent. In a survey of literature of that period, nothing was found concerning the role of the father. Hospitals tended to be procedure centered rather than patient centered, and in training centers there was


16Ibid., p. 45.
little room for fathers. The organization of nursing activities and functions centered around technical and administrative roles rather than the emotional needs of patients.17

Until about twenty years ago, most babies were born at home in the United States,18 as they still are in many countries of the world.19 The father may not always have felt free to be at the bedside of the mother during childbirth, but he was usually close at hand, if he was needed. Literature does not record just what the father’s role was, but he was in the birth room in some areas, and took an active part.20 Of course, during war time in any era, many women had to face childbirth alone, while their husbands fought on the battlefields. No data was found in professional literature concerning the problem of family separation at such a time, before World War II, but many historical novels and early fiction depicted the mother who had to face childbirth alone, having a difficult time, often dying in childbirth.

Soon after World War II, a study was made in California of the problems of fathers and children born while they were away from home. This study showed that parents have more difficulty adjusting to the first child but it was especially hard for the father to accept the child who was born while he was away from home.21 They found it easier to


18Bookmiller and Bowen, loc. cit.

19Simmons, op. cit., p. 989.

20Ibid.

accept the responsibilities of parenthood if they could be with their family when the child was born.  

"A man may get the wrong first impression of himself as a father," wrote Doctor Spock, "when the baby is born in a hospital... he has to wait around alone for hours while the baby is being born, feeling useless and miserable." The laboring mother needs companionship at this time, too. Hazel Corbin wrote a decade ago that "one of the greatest mistakes of obstetrics is the custom of leaving the mother in labor alone..."  

In the hospitals from 1920 to 1940, the schedules were very rigid. Fathers were kept from mothers in labor, and babies were kept in a separate nursery during the postpartum period. In their preoccupation with the prevention of infections, hemorrhages, and other complications of intrapartum, nurses tended to forget to consider the feelings of individual mothers.

IV. RECENT TRENDS TO INCLUDE THE FATHER IN THE LABOR ROOMS

Many obstetricians, nurses, and hospitals have been recently studying the problem of the family in pregnancy and delivery. During

22 Ibid., pp. 51-57.


26 Patricia Murphy, "What is Complete Obstetrical Care?" Nursing World, 129: 11-13, May, 1955.
Sloane Hospital for Women also found that some husbands want to be with their wives in the labor room and others prefer to remain in the waiting room until after the baby is born. They appreciate being able to make the decision themselves.32

Some recent books for expectant mothers suggest the possibility of the father being with the labor patient.33 They are careful to explain that it does not always occur. Not all doctors or nurses accept the father on the maternity team, except under special conditions. A recent obstetrical textbook suggests:

"If the patient is in a room by herself, it is generally desirable for the husband to be with her during labor. Since some husbands become tense and emotionally unstable, they may be of little help, so this matter must be determined on an individual basis. In any case, the husband should leave the room during examinations and treatments."34

In 1956, the Maternal and Child Health Interdivision Council of the Colorado League for Nursing compiled a Guide for Safe Nursing Care of Obstetric Patients and Newborn Infants. It states, "the expectant father should be allowed to participate in the care of the wife during labor."35


World War II a few hospitals began to permit the father in the labor room with the mother. Some doctors and nurses resented him until they found him a valuable support to the mother in labor and a helpful member of the maternity team.27

Much of the pressure for change in management of labor came from the parents themselves. When hospitals or individuals interested in maternity care made surveys to find out how parents felt about the care they had received in the maternity departments, many asked to have the father with them.28 One lay magazine published a letter from a nurse who regretted the manner in which some maternity patients were treated. A report on the responses from mothers showed that ninety per cent of the women wanted their husbands with them during labor.29 One university school of nursing sent a questionnaire to 300 unselected expectant first-time fathers. Fifty-one per cent definitely wanted to be with their wives during labor, thirty-one per cent felt she would be better off if left to the care of the doctors and nurses, one per cent felt the man had no business in the labor room, and many other wrote that they would like to be with their wives if the technical care was left to the medical profession.30 Most men are "keen to take part in the birth of their baby, rather than wait anxiously in the hall or father's room."31


28Christine S. Smith, "We Asked the Patient," Nursing Outlook, 6: 458-459, October, 1958.


maternity patients, only three permit the father in the labor rooms throughout labor, one does not permit him at any time, and the others permit him at the convenience of the nursing personnel, See Appendix A.

Where the father has been accepted in the labor rooms, reports have been encouraging. There have been few complaints that fathers have disturbed the staff because of increased tenseness or apprehension. Some doctors and nurses have felt that the father has contributed a great deal to the emotional support of the labor patient. One study reported that seventy of eighty-three mothers were grateful for the presence of the father in the labor room. In letters from fathers, Keane reported that "the togetherness they've had in labor is mentioned more often than any other factor as a source of satisfaction to both parents."

In his book, Psychoprophylactic Preparation for Painless Childbirth, Isidore Bonstein suggests:

By his presence and his moral help he contributes to create this feeling of achievement so magnificently developed in psychoprophylactic painless childbirth. Undoubtedly the family links are reinforced by this cooperation in a difficult moment.

In a letter quoted in the same book, one father wrote:

By all means, if husband and wife desire, have the husband with his wife constantly. There is nothing in a normal birth which would make a husband induce tension in his wife, and even in emergency cases the average fellow would be more of a calming influence than a disturbing one. The mutual effects of being separated, even for a short time as during the preparation

36Laird, loc. cit.


39Bonstein, loc. cit.
procedures like shaving, etc., undoubtedly cause much more harmful anxiety than the knowledge that dangerous conditions exist...\(^40\)

Implications for the nursing profession were given in a recent study of nurse-patient relationships, in which the statement was made:

If every couple who wished to participate together in the labor experience were permitted to do so, nurses would be able to carry out technical functions without bearing the responsibility for currently prevalent, and often needless deprivations forced onto patients. In the absence of the husband...could not some other person...offer the warmth and emotional support that the women need?\(^41\)

In the survey of literature, nothing was found about the effects upon nursing care or total nursing time when the father was permitted to be at the bedside during labor.

\(^40\)Ibid., p. 57.

CHAPTER III

METHODOLOGY

I. THE METHOD SELECTED FOR THE STUDY

The descriptive or normative survey was the most appropriate research method for this study. The survey may be used when a simple method of research is needed to "solve local problems," to determine the "nature of physical conditions," or to "enumerate the frequency of occurrence of some type of event." Data secured in surveys are usually quantitative. Normative survey constitutes a way of obtaining exact facts and figures about a current situation, and attempts, whenever possible, to draw "valid general conclusions from the facts discovered."2

Although the survey method may be used for the purpose of ascertaining facts, it is normally used in relation to specific interests and situations, so that facts obtained may be used to stimulate deeper thought and application to particular problems.3


Problems of a practical nature are not solved directly by data of any kind, since the solving of problems is a distinctly psychological process. Solutions...result from thinking, with the help of the increased insight that grows out of a study of data or evidence.  

II. THE INSTRUMENT DEVELOPED FOR USE

Of the six broad techniques used in normative survey research, the observation seemed best fitted to this study. It is the method of choice when the researcher is primarily interested in studying the overt behavior of people. 

"Observation involves unbiased selection of pertinent facts essential for validation or invalidation of the hypothesis and for collection of data needed for the establishment of causal relationships."  

Non-participant observation is a technique whereby an observer is assigned to observe all personnel or activities in a given area for a given period of time. It usually includes a carefully planned observation schedule with appropriate means of recording data. The items chosen to be observed are limited to pertinent and reliable items which are important to the study.

---

4 Ibid., p. 552.  
5 Ibid., p. 647.  
8 Travers, op. cit., pp. 229-230.
The observation plan and guide. Direct nursing activities in the labor rooms were classified into five broad areas. They were (1) signs of progress, (2) treatments and medications, (3) personal hygiene, (4) safety measures, and (5) other direct activities. All that was to be included in each nursing activity area was listed in a guide. See Appendix B. The classifications were derived from a modification of areas of nursing care presented by the authors or recent obstetric textbooks. The classifications were made as simple as possible.

The observation record sheet. When the five areas of labor room nursing had been classified and defined, a recording sheet was formed. It was not desirable to know the name of any patient, so the hospital number was used to make it possible to refer to the chart at a later date, if necessary. Selected variables, which could be recorded, though not specifically studied at this time, were age, nationality, religion, prenatal class attendance, and length of time in the labor room.

Data which could be obtained from the patient's chart were placed at the top of the column, as well as a place for comments of the father which might reveal his feelings concerning being permitted in the labor room. The body of the sheet was lined to facilitate recording observations. At the bottom of the lines was a space for totals in time for each activity area and brief definitions of the coding systems. A sample sheet is shown in Appendix C. Observational data of three patients could be recorded on each sheet.

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The coding system. To simplify the recording of observations, a coding system was devised. One code figure was used to represent a nursing activity area. It was believed that it might be confusing to use the figure "1", so figures "2"-through "6" were selected. They were used in consecutive order with "2" signifying signs of progress, "3", treatments and medications, "4", personal hygiene, "5", safety measures, and "6" signifying other direct activities.

Since the father could be present at either hospital, a second system of coding was planned to designate the presence or absence of the father. The code "1" meant that the father was present, "-", that he was in the hospital but not in the labor room. The code "0" meant that he was out of the hospital.

III. THE SOURCE OF DATA

The location. Two private hospitals of comparable size were chosen for collecting the data. A telephone survey was made to learn which hospitals in Denver, Colorado, permitted the fathers in the labor rooms. Of nine general medical hospitals, a variety of practices were reported. Details were given in Appendix A. Only three hospitals encouraged the presence of the father in the labor room throughout labor, and only one refused to allow the father in the labor room at any time.

Results of the telephone survey suggested difficulty in obtaining a hospital in which to observe nursing care of labor patients whose husbands were not with them. Hospital A encouraged the fathers in the labor room, and Hospital B permitted them when a delivery was not in progress or the nurses were not too busy. Both had four labor rooms and two delivery rooms. The conduct of labor was under the direct
control of private physicians. It seemed likely that direct nursing care of enough patients could be observed from both hospitals to test the hypothesis.

Letters were written to the director of nursing service in both hospitals, explaining the purpose of the proposed study, and requesting permission to observe direct nursing activities of selected patients in the labor rooms. Affirmative replies were given, one verbally, the other by letter. See Appendix D.

The pilot study. A pilot study was done to test the adequacy of the observation record sheet and to determine the most reliable method of observation. The labor room nurses were acquainted with the observation schedule, the recording sheet, and the coding definitions. The self-observation method was used by the labor room nurses for one day. Then non-participant observation was employed for a day and results compared. All intrapartum nurses agreed that non-participant observations were less time consuming for them, and less confusing. There were periods in the self-observations which had not been recorded when the nurses were very busy, so non-participant observation was believed to be more reliable. The observation record sheet was accepted with only minor changes made in the columns of the record.

It was recommended that the observer wear street clothes and a laboratory coat while in the corridor, so that patients would not mistake her for a staff nurse.

The population. Since one individual was to do all of the observations, it was recognized that patients could not always be observed for direct nursing care throughout their stay in the labor rooms. It was decided to accept for observation of direct nursing care, any married primiparous woman who was established in labor and whose cervix
was not more than three to four centimeters dilated when the observations began. Length of labor for the primigravida usually averages about ten to fifteen hours. By accepting the patient who was only three to four centimeters dilated, the observer could observe her nursing care for several hours. Observations continued until the patient was transferred to the delivery room. If the patient had not been transferred to the delivery room at the end of six hours of observation, the observation was not completed. One observer can observe and record accurately for about four to six hours, depending upon the number of people being observed, so this criterion was used.

It was also recognized that fewer observations could be made by one observer than could be made if each nurse recorded her own nursing time, or there were several non-participant observers. It was decided to make observations until a definite pattern developed in direct nursing time recorded. There were to be at least ten observations, divided equally between the mothers who had the father with them and the mothers who did not have the father with them.

The nursing care of sixteen labor patients was observed. Eight mothers had the father with them, eight did not. Observations were done whenever either hospital had primiparous patients in labor on Fridays from June 18th to September 18th, 1959.

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IV. THE STATISTICAL METHODS

The arithmetic mean. Because of an expected variation in the length of observations, it was decided to use the arithmetic mean to find the average length of time in minutes each patient received direct nursing care. The arithmetic mean is generally the more reliable and accurate measure of central tendency, and is better suited to other arithmetical computations when they are desired. 12

The chi-square. The significance of difference had to be tested in order to determine the reliability of the study. Chi-square was chosen for this study. This is a statistical method of testing to determine whether there is a significant difference between two or more groups. When an over-all comparison is desired, it is the test of choice. 13 It is commonly used in connection with data that can be reduced to frequencies. Chi-square is the "sum of ratios. Each ratio is that between a squared discrepancy or difference and an expected frequency." 14 Fisher's table of chi-square was used to interpret the total amount of discrepancy and to find the probability of reoccurrence. 15


14 Guilford, op. cit., pp. 228-229.

15 Ibid., p. 540.
CHAPTER IV

ANALYSIS AND INTERPRETATION OF DATA

The purpose of this study was to observe and time direct nursing care given to primigravidae in the labor rooms when the fathers were present or absent, and, from an analysis of the information obtained, determine whether or not there was a significant difference in the amount of time spent in direct nursing care by the labor room nurse when the fathers were in or out of the labor room.

The data presented and analyzed in this chapter were obtained by non-participant observation of sixteen labor patients in two private hospitals. Two groups of patients were observed. In one group the fathers were with eight of the mothers. In the other group the fathers were not with the eight mothers. For the purpose of simplicity, the eight mothers who had the fathers with them will be referred to as Group One in this chapter, and the eight mothers who did not have the fathers with them will be referred to as Group Two.

When all observations were complete, the data were organized and tabulated. Findings were presented for discussion and analysis under three general areas: (1) Total time spent in direct nursing care of each group, (2) Distribution of nursing time in both groups, and (3) Implications of the study.

The data which pertained specifically to this study were arranged into tables, including select known and observable variables which were
not controlled. Each of the eight patients in each group were given a number in the order in which they were observed.

I. TOTAL TIME SPENT IN DIRECT NURSING CARE OF EACH GROUP

Table I showed the total time spent in direct nursing care of eight of the labor patients when the fathers were with them throughout the labor room experience. In order to obtain the minutes per hour that direct nursing care was given, and the time in per cent that nursing care was given, it was necessary to include the total time in which the nursing care was observed for each patient, and the total minutes that nursing care was given to each patient.

The length of observations varied from two hours and sixteen minutes to five hours and twenty-five minutes in Group One, as shown in Table I. All were diagnosed as being in true labor, and examination by the doctor judged dilatation of the cervix on all under four centimeters. Since observation time varied, the mean minutes per hour was used as the index to the amount of time given to direct nursing care.

When the fathers were in the labor rooms, nursing time averaged 7.28 minutes per hour, ranging from 5.76 to 8.59 minutes. The patient who received 5.76 minutes per hour of direct nursing care had been in the hospital seven hours when observations began, but was progressing slowly. There were several multiparous patients in labor, and several deliveries occurred during the time she was observed, which may account in part for the reason she received less direct nursing care per hour than any of the other patients. The patient who received 8.59 minutes of nursing care per hour, was in the labor rooms just two hours and sixteen minutes before she was transferred to the delivery rooms. Direct
## TABLE I

TOTAL TIME SPENT IN DIRECT NURSING CARE OF EIGHT PRIMIPAROUS PATIENTS IN THE LABOR ROOMS OF TWO PRIVATE HOSPITALS WHEN THE FATHERS WERE PRESENT

<table>
<thead>
<tr>
<th>Pt. No.</th>
<th>Total minutes nursing care observed</th>
<th>Total minutes nursing care given</th>
<th>Minutes per hour nursing care given</th>
<th>Per cent of time in labor rooms pt. received direct nursing care</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>220</td>
<td>27.5</td>
<td>7.49</td>
<td>12.5%</td>
</tr>
<tr>
<td>2</td>
<td>210</td>
<td>23.5</td>
<td>6.72</td>
<td>11.0</td>
</tr>
<tr>
<td>3</td>
<td>300</td>
<td>40.0</td>
<td>8.0</td>
<td>13.0</td>
</tr>
<tr>
<td>4</td>
<td>295</td>
<td>37.5</td>
<td>7.62</td>
<td>12.0</td>
</tr>
<tr>
<td>5</td>
<td>250</td>
<td>24.0</td>
<td>5.76</td>
<td>9.6</td>
</tr>
<tr>
<td>6</td>
<td>136</td>
<td>19.5</td>
<td>8.59</td>
<td>14.0</td>
</tr>
<tr>
<td>7</td>
<td>235</td>
<td>27.0</td>
<td>6.84</td>
<td>11.5</td>
</tr>
<tr>
<td>8</td>
<td>325</td>
<td>39.0</td>
<td>7.20</td>
<td>12.0</td>
</tr>
</tbody>
</table>

Totals 1971  238.0  58.22

Means 246  29.75  7.28  11.95
nursing care was observed throughout her stay in the labor rooms. It may be that the rapidity with which she progressed in labor accounted for the increased amount of direct care which she received. Fourteen per cent of the time she was in the labor rooms, a nurse was at her bedside, giving some kind of direct nursing care. The mean per cent for the eight mothers in Group One was 11.95.

Table II presented the findings of the direct nursing care given to mothers when the fathers were not able to be with them during the labor room experience. Time for observing varied from one hour and thirty-three minutes to seven hours and sixteen minutes. In the latter case, the mother was said to be ready for the delivery room momentarily, for over two hours before she was transferred. Since the observer did not feel tired, and there were no other patients in labor to observe, she continued observations until the patient was taken to the delivery room.

The minutes per hour of nursing care given to the mothers in Group Two when the fathers were not with them ranged from 8.46 to 16.13. The mean was 10.85. This was a thirty-three per cent increase in nursing care over that which the mothers received when the fathers were with them. Whereas only one patient received direct nursing care as much as fourteen per cent of the time she was in the labor room in Group One, none of the patients in Group Two received less than fourteen per cent. The mean per cent was 17.98, and the range was from fourteen to twenty-seven per cent.

A comparison of the mean minutes per hour of each of the patients in each group was shown in Figure 1. There the means for both groups were given. At only one place did the lines meet. It was found that only one patient received as little time in direct nursing care in Group Two as the one patient in Group One who received the most direct care.
TABLE II

TOTAL TIME SPENT IN DIRECT NURSING CARE OF EIGHT PRIMIPAROUS PATIENTS IN THE LABOR ROOMS OF TWO PRIVATE HOSPITALS WHEN THE FATHERS WERE ABSENT

<table>
<thead>
<tr>
<th>Pt. No.</th>
<th>Total minutes nursing care observed.</th>
<th>Total minutes nursing care given.</th>
<th>Minutes per hour nursing care given.</th>
<th>Per cent of time nursing care given.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1436*</td>
<td>61.5</td>
<td>8.46</td>
<td>14.0%</td>
</tr>
<tr>
<td>2</td>
<td>360</td>
<td>67.0</td>
<td>11.17</td>
<td>18.6</td>
</tr>
<tr>
<td>3</td>
<td>98</td>
<td>17.5</td>
<td>11.29</td>
<td>18.8</td>
</tr>
<tr>
<td>4</td>
<td>197</td>
<td>36.0</td>
<td>10.98</td>
<td>18.0</td>
</tr>
<tr>
<td>5</td>
<td>325</td>
<td>48.0</td>
<td>8.86</td>
<td>14.8</td>
</tr>
<tr>
<td>6</td>
<td>225</td>
<td>60.5</td>
<td>16.13</td>
<td>27.0</td>
</tr>
<tr>
<td>7</td>
<td>210</td>
<td>34.0</td>
<td>9.71</td>
<td>16.0</td>
</tr>
<tr>
<td>8</td>
<td>192</td>
<td>32.0</td>
<td>10.0</td>
<td>16.6</td>
</tr>
</tbody>
</table>

Totals 2038                                356.5                             86.76

Means 255                                  44.56                             10.85                               17.98

*Transfer to the delivery room was expected momentarily for two hours, so the observation continued past the recommended six hours.
Figure 1. Mean minutes per hour sixteen primiparous patients received direct nursing care in the labor rooms of two private hospitals when the father was present and absent.
The mean was raised 0.81 minutes per hour in the second group by the direct nursing care received by patient number six, who received an average of 16.13 minutes an hour. She had attended prenatal classes and was twenty-nine years of age. She seemed very tense and afraid. The father could have been with her part of the morning, but preferred to wait in the Fathers' Room. Labor progressed rapidly after she was sedated, and she required very close watching with each contraction. The nurses were very busy with several other patients, and five deliveries occurred during the morning, so she did not receive more care than was believed necessary.

It was recognized that a study of sixteen patients was too small to go beyond making some inferences. However, a pattern was in evidence. The problem of chance occurrence of such findings was considered. A chi-square was done to determine the significance of the differences found. The mean minutes per hour of each of the patients in Groups One and Two were used for the observed figures. The chi-square was 72.68. At the seventh degree of difference it was found that there was one chance in more than one thousand that the findings of the study occurred by chance. There was a significant difference in nursing time for the two groups.

II. DISTRIBUTION OF NURSING TIME

One of the questions which was raised at the beginning of the study was, "What area of nursing is influenced most, and to what extent?" To find the answer to that question, it was necessary to analyze the areas of direct nursing care, and the time consumed in each area. These were tabulated and arranged into tables. All five areas were considered
in one table for each group. Table III presented the breakdown in
direct nursing time for Group One, when the fathers were present.

Of the 7.28 mean minutes per hour of direct nursing time received
by each mother in Group One, 3.93 minutes were spent in observing the
signs of progress of labor, 0.31 minutes for treatments and medications,
0.70 minutes for personal hygiene, 2.15 minutes for safety measures, and
0.19 minutes for other direct activities which were not included in the
other four areas. More than half of the time was spent in observing
signs of progress. Nearly one-third of the time was used in guarding
the safety of the mother and child. The other three areas, together,
took only one-sixth of the nursing time.

No treatments or medications were observed being administered to
three patients. Two had received medication just before the observer
arrived, and one patient was using the natural childbirth method and
received no medications. This patient received 6.84 minutes per hour
in direct nursing care. Two did not receive other direct activities,
and only one received as much as 0.27 minutes per hour.

The findings of the analysis of data for Group Two, when the fathers
were absent, was presented in Table IV. Of the 10.85 mean minutes per
hour of direct nursing time per patient, 4.51 minutes were spent in
observing signs of progress, 0.41 minutes for treatments and medications,
1.57 minutes for personal hygiene, 3.10 minutes for safety measures, and
1.23 minutes in other direct activities. There was an increase in direct
nursing care in every area, including medications and treatments. There
were three patients in Group Two, also, who had received their medications
before the observer arrived. Patient number two was catheterized, which
increased the nursing time for treatments for her.
### TABLE III

MINUTES PER HOUR OF DIRECT NURSING TIME IN FIVE AREAS OF INTRAPARTUM NURSING FOR EIGHT LABOR PATIENTS IN TWO PRIVATE HOSPITALS WHEN THE FATHERS WERE PRESENT

<table>
<thead>
<tr>
<th>Pt. No.</th>
<th>Observing Signs of Progress</th>
<th>Treatments and Medications</th>
<th>Personal Hygiene</th>
<th>Safety Measures</th>
<th>Other Direct Activities</th>
<th>Total Minutes per Hour</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3.81</td>
<td>0.41</td>
<td>0.82</td>
<td>2.18</td>
<td>0.27</td>
<td>7.49</td>
</tr>
<tr>
<td>2</td>
<td>4.0</td>
<td>0.29</td>
<td>0.57</td>
<td>1.86</td>
<td>0.0</td>
<td>6.72</td>
</tr>
<tr>
<td>3</td>
<td>4.70</td>
<td>0.0</td>
<td>0.6</td>
<td>2.10</td>
<td>0.6</td>
<td>8.0</td>
</tr>
<tr>
<td>4</td>
<td>3.76</td>
<td>0.81</td>
<td>0.61</td>
<td>2.34</td>
<td>0.1</td>
<td>7.62</td>
</tr>
<tr>
<td>5</td>
<td>3.12</td>
<td>0.0</td>
<td>0.72</td>
<td>1.92</td>
<td>0.0</td>
<td>5.76</td>
</tr>
<tr>
<td>6</td>
<td>4.41</td>
<td>0.88</td>
<td>0.44</td>
<td>2.64</td>
<td>0.22</td>
<td>8.59</td>
</tr>
<tr>
<td>7</td>
<td>3.7</td>
<td>0.0</td>
<td>1.02</td>
<td>2.04</td>
<td>0.13</td>
<td>6.84</td>
</tr>
<tr>
<td>8</td>
<td>3.97</td>
<td>0.09</td>
<td>0.83</td>
<td>2.12</td>
<td>0.18</td>
<td>7.20</td>
</tr>
</tbody>
</table>

**TOTAL MIN.** | 31.47 | 2.48 | 5.61 | 17.20 | 1.50 | 58.22 |

**MEAN MIN.** | 3.93 | 0.31 | 0.70 | 2.15 | 0.19 | 7.28 |
<table>
<thead>
<tr>
<th>Pt. No.</th>
<th>Observing Signs of Progress</th>
<th>Treatments and Medications</th>
<th>Personal Hygiene</th>
<th>Safety Measures</th>
<th>Other Direct Activities</th>
<th>Total Minutes per Hour</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3.44</td>
<td>0.48</td>
<td>1.79</td>
<td>1.72</td>
<td>1.03</td>
<td>8.46</td>
</tr>
<tr>
<td>2</td>
<td>3.92</td>
<td>1.50</td>
<td>1.58</td>
<td>3.42</td>
<td>0.75</td>
<td>11.17</td>
</tr>
<tr>
<td>3</td>
<td>5.48</td>
<td>0.0</td>
<td>2.26</td>
<td>2.90</td>
<td>0.65</td>
<td>11.29</td>
</tr>
<tr>
<td>4</td>
<td>5.03</td>
<td>0.0</td>
<td>1.22</td>
<td>3.96</td>
<td>0.76</td>
<td>10.98</td>
</tr>
<tr>
<td>5</td>
<td>3.60</td>
<td>0.0</td>
<td>1.85</td>
<td>2.68</td>
<td>0.74</td>
<td>8.86</td>
</tr>
<tr>
<td>6</td>
<td>5.13</td>
<td>0.40</td>
<td>2.0</td>
<td>4.87</td>
<td>3.73</td>
<td>16.13</td>
</tr>
<tr>
<td>7</td>
<td>4.57</td>
<td>0.57</td>
<td>0.71</td>
<td>3.29</td>
<td>0.57</td>
<td>9.71</td>
</tr>
<tr>
<td>8</td>
<td>4.92</td>
<td>0.31</td>
<td>1.17</td>
<td>1.95</td>
<td>1.64</td>
<td>10.00</td>
</tr>
<tr>
<td></td>
<td>TOTAL MIN.</td>
<td>36.09</td>
<td>3.26</td>
<td>12.58</td>
<td>24.79</td>
<td>9.87</td>
</tr>
<tr>
<td></td>
<td>MEAN MIN.</td>
<td>4.51</td>
<td>0.41</td>
<td>1.57</td>
<td>3.10</td>
<td>1.23</td>
</tr>
</tbody>
</table>
Group Two received over twice as much nursing care for personal hygiene as Group One did. Nursing time for observing signs of progress and for safety measures, showed a marked increase over Group One. The nursing time used for other direct activities was five times, or five hundred per cent more than Group One. No patient received less than 0.57 minutes per hour in other direct activities. One received as much as 3.73 minutes per hour, more than twice as much as all of the patients in Group One received together. That was the patient who received a total of 16.13 minutes of direct nursing care per hour. She also received more nursing time for observing safety measures than any of the other patients, a mean of 4.87 minutes per hour.

The distribution or mean time according to area was presented graphically in Figure 2. Group One received a mean of 7.28 minutes and Group Two received a mean of 10.85 minutes of direct nursing care each hour they were in the labor rooms.

III. IMPLICATIONS OF THE STUDY

As soon as the findings were tabulated, the question arose concerning the quality of care which was given to each patient group. This study did not attempt to study the quality of nursing care given, in any degree. However, it was noted that only once was a call light seen above the door of Group One, while there were numerous lights from Group Two. Why this occurred was not determined, but there was no evident indication that patients were neglected in either group. The policy of both hospitals was to check on each patient every half hour, and more often if conditions indicated the need.
Figure 2. Mean minutes per hour of direct nursing care received in five general areas of intrapartum nursing by sixteen primiparous labor patients, comparing time when the fathers were present or absent.
At the beginning of the study the possibility of nationality, religion, age, or attendance at prenatal classes, affecting the amount of direct nursing care sought by each patient was considered. These data were recorded on the observation sheet. Findings were presented in Table V and Table VI. Too few patients were observed to make any predictions about the affect any of these variables had upon direct nursing care. All but one of the patients were Anglo-American. The other one was Jewish. Most of them were of some Protestant faith. There was one Catholic and two were of the Jewish religion.

Age has been considered a factor influencing labor and delivery by some. The ideal age for beginning childbearing has been set between twenty and twenty-five years.\(^1\) Toxemia with persistent hypertension has been found more prevalent in women over forty years of age.\(^2\) The ages of the mothers in Group One ranged from nineteen to thirty-eight years. The mean age was 25.5. Group Two ranged in age from eighteen to twenty-nine years. Their mean age was 24.5. Ages for the two groups were distributed as follows:

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Group One</th>
<th>Group Two</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 20 years</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>20 to 24 years</td>
<td>4</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>25 to 29 years</td>
<td>0</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>30 years or over</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
</tbody>
</table>


\(^2\)Ibid., p. 82.
TABLE V

TOTAL TIME IN LABOR ROOM, PRENATAL CLASS ATTENDANCE, AGE, RELIGION AND NATIONALITY OF EIGHT PRIMIPAROUS PATIENTS IN TWO PRIVATE HOSPITALS WHEN THE FATHERS WERE WITH THEM IN THE LABOR ROOMS.

<table>
<thead>
<tr>
<th>Pt. No.</th>
<th>Time in labor rooms. Hours-Minutes</th>
<th>Attendance at Prenatal Classes</th>
<th>Age</th>
<th>Religion</th>
<th>Nationality</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>6 - 04</td>
<td>No</td>
<td>30</td>
<td>Baptist</td>
<td>White</td>
</tr>
<tr>
<td>2</td>
<td>10 - 50</td>
<td>No</td>
<td>23</td>
<td>Presbyterian</td>
<td>White</td>
</tr>
<tr>
<td>3</td>
<td>10 - 45</td>
<td>No</td>
<td>20</td>
<td>Protestant</td>
<td>White</td>
</tr>
<tr>
<td>4</td>
<td>18 - 05</td>
<td>Yes</td>
<td>32</td>
<td>Episcopal</td>
<td>White</td>
</tr>
<tr>
<td>5</td>
<td>11 - 40</td>
<td>No</td>
<td>38</td>
<td>Methodist</td>
<td>White</td>
</tr>
<tr>
<td>6</td>
<td>2 - 26</td>
<td>No</td>
<td>19</td>
<td>Protestant</td>
<td>White</td>
</tr>
<tr>
<td>7</td>
<td>5 - 15</td>
<td>No</td>
<td>22</td>
<td>Protestant</td>
<td>White</td>
</tr>
<tr>
<td>8</td>
<td>6 - 10</td>
<td>Yes</td>
<td>20</td>
<td>Catholic</td>
<td>White</td>
</tr>
<tr>
<td>MEANS</td>
<td>8 - 48</td>
<td>No</td>
<td>25.5</td>
<td>Protestant</td>
<td>White</td>
</tr>
</tbody>
</table>
### TABLE VI

TOTAL TIME IN LABOR ROOM, PRENATAL CLASS ATTENDANCE, AGE, RELIGION AND NATIONALITY OF EIGHT PRIMIPAROUS PATIENTS IN TWO PRIVATE HOSPITALS WHEN THE FATHERS WERE NOT WITH THEM IN THE LABOR ROOMS.

<table>
<thead>
<tr>
<th>Pt. No.</th>
<th>Time in labor rooms (Hours-Minutes)</th>
<th>Attendance at Prenatal Classes</th>
<th>Age</th>
<th>Religion</th>
<th>Nationality</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>14 - 36</td>
<td>No</td>
<td>27</td>
<td>None</td>
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</tr>
<tr>
<td>2</td>
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<td>18</td>
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<tr>
<td>3</td>
<td>20 - 30</td>
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<td>28</td>
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<tr>
<td>4</td>
<td>13 - 47</td>
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<td>7 - 50</td>
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<td>8</td>
<td>10 - 27</td>
<td>No</td>
<td>21</td>
<td>Christian</td>
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</tbody>
</table>

**MEANS** 11 - 09  No 24.5 Protestant White
In Group One, the patient who received the least amount of direct nursing care was thirty-eight years of age, and the one who received the most care was nineteen. In Group Two, the one who received the least amount of direct nursing care in time was twenty-seven years old, and the one who received the most care was twenty-nine. From these figures no conclusions were drawn. More direct nursing care for mothers would have to be observed before any indications would be apparent. And the interaction of physical, physiological, and emotional factors are difficult, if not impossible, to separate and evaluate concerning their separate affects upon labor.\(^3\)

One factor which would have bearing upon the amount of time in which the nurse must give direct nursing care to any one patient, was the length of labor. If the patient had a short labor, the amount of total direct nursing care would be diminished. Conversely, if the labor was long, direct nursing care would be increased. A record was kept of the length of time each patient spent in the labor room. Group One varied from two hours and twenty-six minutes to eighteen hours and five minutes. The mean length of time was eight hours and forty-eight minutes.

Group Two had a wide range, also, varying from four hours and fifteen minutes to twenty hours and thirty minutes. Their mean length of time was eleven hours and nine minutes. The length of time for each patient was presented in Table V and Table VI. A graphic presentation was given in Figure 3. There was a mean increase of 2.35 hours per patient when the fathers were not present. However, there was a wide

\(^3\)Ibid., p. 202.
Figure 3. The number of hours sixteen primigravidae spent in the labor rooms of two private hospitals when the fathers were present or absent.
range, and many things contribute to the length of labor. It cannot be
definitely stated that the length of labor was shortened when the father
was present, but the results of this study would seem to indicate that
there is a possibility that it was.

The implications of the data presented in this chapter suggest
that the nurse in the labor rooms will spend less time in direct nursing
care when the father is permitted to be with the mother during her labor.
The hypothesis that there would be no significant difference in the
amount of time direct nursing care given to the labor patient whether
the father was present or absent, was nullified by the findings of this
study. There was a significant difference in every area of direct
nursing care for the sixteen patients observed.
SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

I. SUMMARY

This study was concerned with the amount of time consumed in direct nursing care of the labor patient when the father was present or absent from the labor room. The problem of total direct nursing time was considered, as well as which of five general areas of intrapartum nursing were influenced most and to what extent.

The purpose of this study was to observe, time, and compare direct nursing care given to primiparous patients in the labor rooms when the fathers were present or absent, to determine if the presence of the father during labor indicated a significant effect upon the amount of direct nursing care given to the labor patient. It was believed the findings would prove useful in helping hospitals examine their own policies concerning the father in the labor room, in teaching student nurses the importance of family-centered nursing care in the labor rooms, in the orientation of new nurses to the maternity services, and in planning In-Service Education.

The study was instituted on the hypothesis that there would be no significant difference in the total amount of direct nursing care given to the labor patient whether or not the father was in the labor room, although there might be some difference in the amount of direct nursing care given in certain activity areas of direct nursing.
This study was confined to the problem of analyzing time spent in direct intrapartum nursing care when the fathers were present or absent. It was a quantitative study rather than a qualitative study. Individual differences of parents were recognized but not dealt with. Sixteen married primiparous patients were selected to observe direct nursing care of, eight with the fathers present, eight with the fathers absent from the labor room.

An historical review of literature revealed that the father was at one time the only accepted attendant of his wife during labor and delivery, and still plays an important role in the birth of his child in many cultures. In other cultures he is rigidly excluded from the labor rooms. In America, the father was excluded from the labor rooms of most hospitals before World War II, and only recently have hospital personnel begun to recognize the important part the father can contribute to the emotional support of the mother in labor. Studies have been made concerning the emotional benefits to both parents when they were together during labor, but nothing was found recorded concerning the effect upon direct nursing time when the father was in the labor room with the mother.

The normative or descriptive survey method of research was found to be the method of choice for this study. Non-participant observation was chosen after the pilot study showed it to be more reliable than self-observation. An observation schedule was planned. The direct nursing activities to be observed were selected and categorized into five areas. These were (1) observing signs of progress, (2) treatments and medications, (3) personal hygiene, (4) safety measures, and (5) other direct activities. An observation record sheet was devised on which to record observations.
A simple coding system was planned to designate the five general areas of direct nursing care and the presence or absence of the father.

The study was made in two private hospitals of comparable size. The policies in the two maternity departments were similar in relation to patterns of nursing care and regulations concerning fathers in the labor room. Both groups were taken from both hospitals.

Because of the expected variation in the length of observations, the arithmetic mean was chosen to find the average time in minutes the patient received direct nursing care. The chi-square was chosen as the statistical method of choice to test the significance of difference in direct nursing time between the two groups.

When the observations had been completed, the data were organized and tabulated, and the findings analyzed and presented in tables and figures. It was found that 3.57 more minutes each hour were used in giving direct nursing care of the labor patient when the father was not present in the labor room. All five areas of direct intrapartum nursing care showed an increase when the father was absent from the labor room. The chi-square revealed a significant difference in the total amount of direct nursing care each group received. There was also found to be an average increase of 2.36 hours in the length of labor of the eight mothers who faced labor alone over the eight mothers who had the fathers with them. It was recognized that with such a small sample to observe, no definite statement could be made, but there was an indication that the length of labor was influenced by the presence of the father.
II. CONCLUSIONS

The hypothesis that there would be no significant difference in the total amount of direct nursing care given to the labor patient whether the father was present in or absent from the labor room was nullified. From an analysis of the data presented in this study the following conclusions were made:

1. Direct nursing care for the sixteen patients observed was decreased 33 per cent when the fathers were with the mother in the labor room. The mean minutes per hour decreased from 10.85 when the father was absent to 7.28 when the father was present, a mean decrease of 3.57 minutes per hour. A chi-square showed that the findings could have occurred by chance in less than one time in one thousand.

2. There was a decrease in nursing care in all of the five areas of direct nursing care studied when the father was with the mother in the labor room. Less than one half as much time was spent in the area of personal hygiene. Treatments and medications showed a slight decrease and there was a marked decrease in the amount of time spent in the areas of observing signs of progress and in safety measures. One fifth as much time was spent in the area of other direct activities when the father was present.

3. Age did not seem to have any significance in the amount of direct nursing care given to either group of patients observed for nursing care.

4. Results of the study indicate a possibility that the length of labor was shortened when the father was with the mother. Of the sixteen patients observed for nursing care, there was a mean decrease
of 2.36 hours in the labor rooms per patient when the fathers were present.

5. The nurse in the labor rooms spent less time in direct nursing care when the father was permitted to be with the mother during her labor.

III. RECOMMENDATIONS

The following recommendations were made as an outgrowth of this study:

1. That parents be permitted to be together during the labor room experience when they so desire.

2. That hospitals reexamine their policies restricting fathers from the labor rooms. Do they have valid reasons for denying parents the experience of being together during labor?

3. That student nurses have the experience of caring for labor patients when the fathers are with them, and that they examine their personal feelings regarding this experience.

4. That a study be made to determine the effect upon the quality of direct nursing care when the father is in the labor room. Such a study should have special significance in the In-Service Education program. Can nurses learn to accept the father as a part of the maternity team so that the quality of care can be improved?

5. That a more extensive study be conducted to determine the effect of the father's presence in the labor room upon the length of labor. From the results of this study there were indications that there may be a direct relationship between the father's presence in the
labor room and the length of labor. There were several possible reasons for the findings. The mother could be more relaxed, thus making each contraction more effective; the father could be performing certain nursing functions, and so helping the nurse; or the nurse may feel less comfortable when the father is present or may hesitate to ask him to leave his wife for a few minutes while examinations are being made.
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A. BOOKS


B. PERIODICALS


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Simmons, Leo W. "Cultural Patterns in Childbirth," The American Journal of Nursing, LII (August, 1952), 989-991.

Smith, Christine S. "We Asked the Patient," Nursing Outlook, VI (October, 1958), 458-459.


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C. UNPUBLISHED MATERIALS


APPENDIX
APPENDIX A

FINDINGS OF A TELEPHONE SURVEY IN MARCH, 1959, TO LEARN WHICH OF NINE GENERAL MEDICAL HOSPITALS PERMITTED THE FATHER IN THE LABOR ROOM WITH THE MOTHER
### FINDINGS OF A TELEPHONE SURVEY, MARCH, 1959, TO LEARN WHICH OF NINE GENERAL MEDICAL HOSPITALS PERMITTED THE FATHER IN THE LABOR ROOM WITH THE MOTHER

<table>
<thead>
<tr>
<th>HOSPITAL</th>
<th>CURRENT POLICIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>The hospital encourages the father to stay unless the doctor advises against it for some reason. He may stay throughout the labor room experience.</td>
</tr>
<tr>
<td>B.</td>
<td>The father may stay unless another delivery is in progress or some patient is too noisy, if they are in a private room. All doctors do not encourage it during working hours.</td>
</tr>
<tr>
<td>C.</td>
<td>All fathers may come in on admission. After the analgesic is given, it is up to the doctor whether he may stay longer. Mothers are sedated quite early in labor.</td>
</tr>
<tr>
<td>D.</td>
<td>It depends upon the wishes of the doctor whether the father can stay. The hospital cooperates either way. More doctors and parents are asking for it. It is encouraged when natural childbirth is used.</td>
</tr>
<tr>
<td>E.</td>
<td>Fathers are free to stay throughout labor except during the examinations. There are no other restrictions. It is up to the parents. Most parents want it.</td>
</tr>
<tr>
<td>F.</td>
<td>Unless another delivery is in progress or expected momentarily, the father may stay. If the patient is restless he may be asked to leave. Three-fourths stay or ask to stay.</td>
</tr>
<tr>
<td>G.</td>
<td>The father may stay until analgesia is given or another delivery is in progress. The father's room is nearby where the father may speak to the nurse at any time. Analgesia is given early, so the father often cannot stay long.</td>
</tr>
<tr>
<td>H.</td>
<td>One person is permitted or requested to stay, either the father or someone else. The nurses are too busy to stay with the mothers.</td>
</tr>
<tr>
<td>I.</td>
<td>The father is never permitted in the labor corridors. Medical and nursing students are in constant attendance of labor patients, the rooms are small, and it has not been felt advisable to have the father there.</td>
</tr>
</tbody>
</table>
APPENDIX B

OBSERVATION GUIDE
**CLASSIFICATION OF DIRECT NURSING CARE ACCORDING TO AREA**

Codes for the activity areas as defined for this study are listed below:

<table>
<thead>
<tr>
<th>CODE</th>
<th>DEFINITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td><em>Observing Signs of Progress</em> includes timing contractions, listening to fetal heart tones, observing vaginal discharge, intensity of contractions, and mother's reactions to the contractions. Rectal examination is included.</td>
</tr>
<tr>
<td>3</td>
<td><em>Giving Treatments or Medications</em> includes giving any medication ordered by the doctor, such as sedatives, analgesics, amnesics, tranquilizers, intravenous fluids, medications or blood given intravenously, and giving treatments such as enemas, catheterizations, or preparing the equipment and patient for the doctor to do a sterile vaginal examination.</td>
</tr>
<tr>
<td>4</td>
<td><em>Personal Hygiene</em> includes assisting with oral care, sponging face or other body parts, assisting to void or defecate, changing buttock pads or other linen, giving liquids or nourishment when permitted, rubbing her back, and all other nursing activities which contribute to the personal comfort of the patient.</td>
</tr>
<tr>
<td>5</td>
<td><em>Safety Measures</em> mean anything which is done at the bedside of the patient to protect her of her baby from physical harm. This includes taking blood pressure, temperatures, pulse, and respirations, observing for complications, applying side rails to the bed when indicated, or applying other types of restraints which will help prevent the patient from falling out of bed or injuring herself, or staying with the patient when she is sedated or excited and is not responsible for her actions.</td>
</tr>
<tr>
<td>6</td>
<td><em>Other Direct Activities</em> mean all activities in the patient's room which are not a part of those classified in the first five areas. It includes informing the patient or her husband of progress of labor, explaining any procedures, waiting for the husband to leave the room when it is indicated, teaching the patient to relax or cooperate with her contractions, exchange of pleasantries with the patient when no other thing is being done for her, and all other activities not considered as direct nursing care.</td>
</tr>
</tbody>
</table>

To indicate the presence or absence of the father in the labor room, a coding system has been devised which makes it easy to record where he was:

- **Father is in the labor room.** If he has been with the mother and will be returning to her as soon as the nurse or doctor are through with their procedures, he is considered present.
- **Father is in the hospital, but not in the room.** This would include the one who waits in the father's room, or the time he might go to eat or rest, or to telephone.
- **Father is out of the hospital.** He may be at home, at work, out of town, or anywhere other than in the hospital where his wife is in labor.
APPENDIX C

OBSERVATION RECORDING SHEET
### LABOR ROOM BESIDE NURSING TIME RECORD

<table>
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<th>Hour</th>
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### TOTALS IN TIME

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<td>+ Father in Room</td>
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<td>3.</td>
<td>Giving Treatments and Medications</td>
<td>- Father in Hospital, out of Room</td>
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<td>4.</td>
<td>Personal Hygiene</td>
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</tr>
<tr>
<td>5.</td>
<td>Safety Measures</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Other Direct Activities</td>
<td>O Father out of Hospital</td>
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</tbody>
</table>
APPENDIX D

LETTERS SENT TO AND RECEIVED FROM THE DIRECTORS OF NURSING SERVICE
Much has been written in the past decade about modern trends in maternity care. A divergence of opinion has been expressed concerning the advisability of including the father in the process of childbirth. One reason used occasionally by both groups, but without statistical proof, is the effect upon nursing care. One group says less care is required, and the other group says more care is required when the father is in the labor rooms.

I would like to do a study of nursing activities within the labor rooms of your hospital to determine the effect upon nursing care of the labor patient when the father is present or absent. I would be in the labor corridor, but not in the room. No nurse would be observed for the care she provided. All data would be held in strict confidence. No names will be used in the study and the name of the hospital will be protected if desired.

The study would also meet one of the requirements for the Master of Science Degree in Nursing which I hope to receive from the University of Colorado in August.

Sincerely yours,
In response to your letter of May 18th, I would like to confirm the verbal permission given you to conduct a study in our Labor and Delivery suite as a part of the requirements for your Master of Science Degree from the University of Colorado.

Mr._________, the Administrator of the hospital and Dr._________, Chief of Obstetrics, have given their approval. Nursing personnel in the unit are willing to cooperate in any way.

Sincerely yours,