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Doulas – *the future guardians of normal birth?*

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For the purpose of this paper, the term 'normal birth' will be defined as true physiological labour and birth, without any methods of induction or augmentation and where the woman has not received any chemical drugs for pain management or any surgical incision.

Introduction

Recent discussion as to whether the role of the doula may be seen as supportive to that of the midwife or merely a threat to the very art of midwifery, raises serious questions about the provision of maternity services in protecting normal birth.[1–5] In a climate where medicalised childbirth prevails,[6] more women are currently employing doulas to ensure one to one care during labour in an attempt to safeguard their chances of a normal birth.[7–9] This article examines the potential rise of the doula as the essential support person to the childbearing woman.

Role of the midwife vs role of the doula

The midwife can provide all the care necessary for a woman and her baby throughout pregnancy, birth and up to 28 days post-birth, as long as the condition of the woman and her baby remain within normal limits. She is equipped to assess any deviation from the normal and to refer to the appropriate medical assistance, from which point she will continue to provide care under medical management. She acts to protect normal birth, to support women physically and emotionally through their childbirth experience using clinical knowledge and skills in education, counselling and health promotion. She stands as an advocate for women's choice.[10]

The doula provides emotional care and practical assistance to a woman and her partner during labour and/or the postnatal period. She can offer information, counsel and social support but she is not trained to carry

out any clinical tasks. She may, however, be trained in other skills such as massage, reflexology, homeopathy or breastfeeding support. She is chosen and employed by the woman or couple to protect the memory of their birth experience, and to assist in their transition to parenthood. Her role derives from the birth support person who traditionally would have been (and still is, in some countries) the woman's mother, sister or friend. She also stands as an advocate through facilitating effective communication between the woman and her caregivers.[11]

The decline of midwifery and the rise of the doula?

Rather than witness an increased presence of doulas within current maternity care, greater resources spent on the midwifery services would allow midwives to fully employ their skills as autonomous holistic practitioners, and in turn refute any role for the doula.[2] Why indeed, if midwives are trained to be 'with woman', should women need a further support person during the time around childbirth?

For midwives with a passion in their hearts to make a real difference to the way women give birth, some may choose to practise independently where they will be able to achieve such aspirations.[12]

For those in the National Health Service (NHS) system, it is often a different story. Quickly disillusioned as their 'hands on' skills are persistently overruled by medical intervention and hospital politics,[13] many feel obliged to surrender any desire to practise holistically in order to avoid being marginalised by their colleagues.[12] Some continue to do what they can to support women's choice piecemeal within a largely hostile environment, but others branch into education or give up their clinical practice entirely.[14] Surely these practitioners are the very essence of what the system needs if it is to come anywhere near providing individualised women-centred care? When asked why they have left the profession, their reasons are clear: they refuse to remain complacent as the midwife becomes an obstetric nurse.[15]

Are we witnessing the demise of midwifery?

It is perhaps not so much that NHS midwives are bereft of the intention to protect normal birth, but more that their practice has been coerced from the reality of normal birth by the routines and protocols of the system.[16] Beds dominate the birthing rooms, the recumbent position is encouraged for vaginal examinations, continuous fetal monitoring is routinely performed,[17] and the rate of epidural anaesthesia is rising.[18] Although the value of medical intervention in appropriate cases is recognised,[12] the percentage of normal births, including those with an epidural, has fallen from 75% to 68% since 1997,[19] with only 44% of women giving birth normally without epidural.[20] However insistent they are that they are supporting women's choice and practising autonomously, midwives adhering to a protocol of two-hourly vaginal examinations are simply perpetuating the medical model of defensive practice.[1] Setting up syntocinon infusions or topping up epidurals ultimately remain procedures under medical management.[16] Some student midwives are currently qualifying without the skills to support a woman through normal birth, having never looked after a labouring women without an epidural *in situ*.[21] These skills require physical and emotional commitment which is truly about being 'with woman', but such an essential part of midwifery care has largely been usurped by copious note-taking, checking of machinery and performing of invasive, often unnecessary procedures.[14] This removal of focus from the woman has serious implications for midwifery practice, as noted in a recent study on one-to-one midwifery care, where the researchers found an actual reluctance amongst many midwives to emotionally support women during normal labour.[22]

Doulas are mostly mothers themselves with a special interest in childbirth issues. Their work has been described as 'mothering the mother'[23] and as 'sisterly support'.[2] The author suggests that the first of these echoes a relationship of co-dependency rather than the more equal footing and empowering bond of the second. The one aspect of the doula's role that is certain, however, is her continuity of care. She is present for the woman or couple, having established their needs prenatally and agreed with them ways in which she might best support them during labour and with their new baby.[24] There are no shift changes for her, and although this means she may work the duration of a long labour, she does not have to be 'on duty' again the following day. Whereas postnatal midwifery care is consistently lacking in real time for listening, educating and guiding women in parenting skills or debriefing after birth, the doula may spend several hours a day for a period of six to eight weeks helping the new mother and baby, supporting breastfeeding, preparing meals and assisting with siblings.[24] At a human level, and as many midwives would also wish,[25] the doula can negotiate her work with a flexibility that allows consideration for the needs of her own family as well, reflecting a partnership in care between client and carer.

Supporting evidence for doulas

Much of the research undertaken on the role of the doula has been done in the United States[26,27] where there exists a fragmented system of midwifery: nurse-midwives, who care for the physical needs of women in hospital and hand over the actual birth event to the doctor, or lay midwives who attend women birthing at home.[28] Doulas thus entered the American childbearing arena in order to provide valuable emotional support to women giving birth in hospital. Further studies have been done in Guatemala, Canada, South Africa, Botswana and Mexico.[29–33]

The evidence on the use of doulas shows a reduction in medical intervention during labour, with lower rates of caesarean section and other instrumental deliveries, and less need for epidural and opiate pain management.[26,27,32] Better rates of breastfeeding have also been indicated as the result of a doula attended birth.[33] Additional findings

attributed to the support of a postnatal doula show improved parent/baby bonding and decreased incidence of postnatal depression.[34]

Although there is similar evidence in support of one-to-one midwifery care,[35] and Government recommendation promotes continuity of carer in an endeavour to decrease medical intervention during labour,[36] recent research suggests this may not be happening.[22] *"Women are giving birth not just in circumstances which are less than optimal emotionally. Some women are giving birth in circumstances which are dangerous."*[5]

As the evidence points to the doula's support being so vital to the labouring and postnatal women, could her role also be considered of some support to the midwife?[37]

In theory, the midwife's role does include that of the doula but, in practice, with the current constraints on NHS resources, staff shortages and demoralisation of midwives, this is often far from reality.[38] Apart from the radical minority practising within the large hospitals,[28] working in a small rural midwife/GP unit or midwife-led birthing centre is perhaps the nearest opportunity that a NHS midwife will get to autonomous holistic practice, and the nearest a childbearing woman will get to the excellent care that she deserves.[25] Despite these pockets of good practice, where women are listened to and their wishes respected by midwives who feel fulfilled in their work, the majority of support for normality in childbirth is substandard.[12] No amount of improvement to the maternity services is ever likely to accommodate true autonomous midwifery practice and women-centred care whilst the existing obstetric hierarchy persists.[38]

Doulas as guardians of normal birth?

Traditionally, midwives have been heralded as the guardians of normal birth,[39] but if they are no longer able,[15] or even in some cases willing[22,40] to provide women with the kind of support they need in order to have the best chance of a normal birth, some alternative must be found. Women who feel strongly about safeguarding normal birth are beginning to increase the volume in voicing their concerns; these include disenchanted midwives, pregnant women (who are employing doulas) and doulas themselves. Some doulas are indeed ex-midwives who have refused to become complicit in the obstetric nurse conspiracy and simply want to get on with the work of supporting the normal physiology of pregnancy, birth and the early days of parenting.[41] The organisation Doula UK has been established, advised by a panel of childbirth practitioners including Sheila Kitzinger, to set standards for doula training, to evaluate the experience of practising doulas, to offer a forum for peer support and to provide information for pregnant women and their partners about local doulas and doula services.[24] In the case of unsupported women or women who are in prison, some doula services are offered on a voluntary basis.[42]

Conclusion

From the discussion raised within this text, it is clear that an increasing number of women are seeking to improve their chances of a normal birth but that they are not guaranteed to receive the support they need from their midwifery services. In a quest to avoid medical intervention during labour and lack of support during the postnatal period, many are making the informed choice to employ a doula as an essential part of their maternity care.

Where the midwifery profession has to a large extent been complacent in its surrender to obstetric nursing, perhaps the rise of the doula is the very issue that will expedite the creation of a formal distinction between midwife and obstetric nurse. The author suggests that in the meantime, midwives might be wise to show their support for women-centred care by embracing the presence of doula colleagues. In this way they may also remain party to the safeguarding of normal birth.

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Current practice for induction of labour in the United Kingdom: *time for a review?*

This paper presents the results of postal survey of protocols for induction of labour. The drug regimes used for the induction of labour in NHS hospitals in England and Wales have been compared to both RCOG guidelines and to the drug manufacturer's recommendations. A wide variation in practice was found, with many units using dosages that are different from those recommended. The implications of such departures from the norm are discussed in terms of the importance of evidence-based practice and the role of national guidelines in ensuring optimum care.

Introduction

While undertaking a regular revision of the Delivery Suite Guidelines, it was noted that our protocols for induction of labour included a number of minor departures from both the RCOG *Clinical Guideline*[1] and the manufacturer's recommended dosage schedule.[2,3] These discrepancies related to a larger maximum dose of prostaglandins for multips and a higher than recommended maximum infusion rate of oxytocin, with no limitation on the total maximum cumulative dose. In view of the increasing importance of evidence-based practice we felt it necessary to review our practice critically to see if we had any valid reasons for not adhering to the recommended schedules. Experience suggested that our guidelines were not dissimilar to those of other units in which staff had