



Mother's mouthpiece or clinician's curse: the doula debate continues

Adela Stockton

Recent media discussion regarding the role of the doula has raised questions about her working boundaries as well as her accessibility to women (Campsie 2009, Murphy 2009). Are doulas overstepping their limits with trained staff? Should doulas be regulated? Why should doula support only be available to those who can afford to pay? This article discusses the fine line between women's choice and clinician's control in view of the questions posed above and mother-led maternity care.

Whether you agree with the existence of the doula or not, the evidence in favour of the benefits of the lay supporter to labouring women, new mothers and their families is clear (Langer *et al* 1998, Goldbort 2002, Hodnett *et al* 2003, McGrath & Kennell 2008). If maternity services are to remain focused on providing individualised care for every mother or couple, then the fact that women are independently seeking the additional support of a trusted confidante to accompany them into the birthing room needs to be taken seriously. Through the lack of midwives with whom to engage in a personalised relationship, the expectant mother is turning to lay women for emotional support — another mother, sister or grandmother, who is well known to her and whom she trusts to act as her advocate. The role of this female companion has been formalised over recent years and allocated the title of 'doula' — meaning 'a woman who serves other women (during childbirth)' (Klaus *et al* 2005).

Frequently, the doula is enlisted because the mother-to-be does not feel confident that her choices and decisions for care during labour and birth are being listened to or will be upheld by the attending midwife and other medical staff (Stockton 2009a). And while her role is categorically not to provide medical advice or clinical intervention, in her position as enlisted by the birthing woman or couple to act on their wishes, the doula is at liberty to question a clinical intervention at the behest of the mother. Hearing the rational voice of a labouring woman is unusual and may be challenging to some maternity practitioners, as trainee anaesthetist Dr Abhijoy Chakladar (2009) discovered when a doula relayed the mother's wishes to him that were contrary to his suggestion that she changed her position. What is said on behalf of a labouring woman may be perceived as having been initiated by the doula, rather than the doula acting on behalf of and with the consent of the mother, and might therefore be seen as antagonistic, even obstructive. Yet rather than stepping on the health professional's toes, as Chakladar suggests, such a situation is perhaps more about the effective communication skills, confidence, and integrity of both

doula and clinician. For if both parties have an understanding of and respect for each other's roles, as well as a mutual focus on what the mother (and her partner) feels is the right care for her, surely there should be no need for anyone to feel threatened or for conflict to arise.

As with every working person, lay or professional, there are occasions where a doula will overstep the boundaries of their role, and it seems reasonable that there should be a system in place to redress this. There is no place for ego within the birth space or 'babymoon' of a new mother; as the word 'doula' suggests, her role is concerned with service, and any doula whose actions are outside the specific wishes of her client is working inappropriately. While statutory regulation for midwives and other trained health professionals sets out '*to ensure standards of practice by regulated practitioners and to protect the public as far as possible against the risk of poor practice*' (DH 2004), what purpose would the initiation of a similar standard serve for the lay, untrained, unqualified worker? It could be argued that it might help to clarify the doula's remit to the trained staff involved in the care of the labouring woman, yet why make her into a professional worker when she is not? What does the doula do that needs to be regulated? As Denise Linay, representative of the Royal College of Midwives, states, while doulas are untrained they can do no harm; she reiterates that doulas should never find themselves in a position where they could cause harm because such action is not within the remit of their working boundaries (Linay 2009). So if statutory regulation is inappropriate to the lay role, could a voluntary system of self-regulation, such as that already established by national network Doula UK, be the solution? In this way, the doula has a framework of standards and code of conduct to work from and an organisation behind her who the public, including health professionals, can turn to should she give them cause to complain (Stockton 2009b). Affiliation to Doula UK currently remains up to the individual doula, but this could provide a way towards doulas adhering to a nationally recognised code of conduct, whilst importantly, maintaining the flexibility to provide individualised mother-led support without becoming 'professionalised'. Where it appears that mothers already feel unsupported by existing professional services, this would suggest that any proposals to professionalise the inherently lay role of the doula could only be counterproductive.

Currently, most doulas are selected by parents-to-be and work independently for a fee, an aspect for which the role is regularly criticised (Langlands 2007), although some

schemes are already in place through which financial support or volunteer doulas are available*. Recent Department of Health funding awarded for further national volunteer doula programmes, which some might argue could have been better spent on recruiting more midwives (Silverton 2009), would suggest that the lay role is gradually becoming officially endorsed. Concern that birthing families should not have to hire in the psychosocial support which would traditionally have been provided by the midwife, or indeed female relatives, is commendable. Yet it has also been suggested that the presence of doulas might be a pragmatic approach to the current crisis, effectively filling some of the 'gaps' in the maternity services (Chakladar 2009). While the doula is not, and never has been, intended to replace the midwife, who remains the lead specialist provider in normal clinical maternity care, the midwifery role has been eroded to its bare bones, thereby minimising women's access to emotional support during the childbirth year. Where mothers are unable to establish a relationship with a midwife, it seems likely that they will continue to turn to doulas to act as their mouthpiece, particularly when attempting to secure the intrapartum care that they feel is right for them. With the majority of doulas working independently of NHS-provided care, a question needs to be raised over how far a doula who is affiliated to a state funded organisation might be able to advocate effectively for a mother, when faced with conflict between the 'system' over the wishes of her client. Could it be that the option for 'provision' of doula support is not only about being seen to replace (apparently) what is fast being drained out of midwifery care, albeit at a cheaper rate, but also a ploy to maintain control over birthing women's voices and choices? While the doula role also extends into postnatal support, an area equally criticised for failing to meet women's needs, a radical thought may be rather than 'providing' doulas for women who cannot afford to pay their fee, why not offer a statutory 'Doula Fund' (something akin to the Health in Pregnancy Grant launched last year) to all expectant mothers to take up if they wish? In this way, the woman remains in control, free to choose the doula that is right for her and her partner, and indeed, to decide whether doula support is right for her at all.

In conclusion, while the majority of doulas may work hard to fulfil the expectations of the mothers and couples who enlist them as well as to forge positive working relationships with any attending health professionals, it is possible that some will overstep their boundaries causing conflict over clarity of roles of those present at a birth. As statutory regulation could be considered unsuitable for the lay role, UK doulas might be well advised to affiliate themselves to an organisation that offers a system of voluntary self regulation, so that they can demonstrate an adherence to a uniform code of conduct while maintaining complete commitment to the wishes of their clients. In view of the positive evidence in favour of doulas, there are persuasive arguments to suggest that all birthing women and families should have access to psychosocial support from a lay person who is chosen and trusted by them to

uphold their wishes for birth and parenting, regardless of who pays the doula's fee. In this way, control over how and where maternity care and support is delivered, and by whom, remains firmly with the mother and her partner, and the needs of the individual remain at the heart of the matter.

* Relevant organisations

Doula UK Hardship Fund — www.doula.org.uk/content/duk/doulauk/Hardship_Fund.asp

Birth Companions — www.birthcompanions.org.uk/howwework.html

Goodwin Volunteer Doula Project — www.goodwindoulas.org

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