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Letters to the Editor

Doctors and doulas in the labor and delivery suite

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Sir,

Maternal stress during labor and delivery is a complex psychological response, which can be influenced by many factors, including the parturient's expectations, her level of education (while many pregnant women present with a significant amount of prior knowledge regarding childbirth, others may have little or no understanding of the labor and delivery), intensity and severity of uterine contractions (labor pain), the labor suite environment and presence (or absence) of a lay support person (1).

The presence of a lay support person in labor does not guarantee the relief of labor-induced psychological stress; however, continuous emotional and physical support, companionship and encouragement during labor can be one of the most effective means of providing safe passage for the pregnant woman and her baby from the antepartum to postpartum period (the transition to motherhood).

Throughout the history of humankind, women have labored and given birth in the presence of other women, whereas

fathers-to-be (women's partners) have only recently assumed a more active role in the childbirth process. Today the doula (the word derived from the Greek doula, meaning a 'woman's servant') – the modern female companion – is gaining increasing popularity and recognition as the best source of peripartum emotional support for the laboring women throughout the world (2). Many fathers-to-be may find it difficult and/or overwhelming to provide doula-type non-medical emotional support and encouragement during labor because of their own psychological involvement in the birth process (3). Indeed, Ip reported that women whose husbands were present during labor used significantly higher dosages of analgesia than those whose husbands were absent, and concluded that those husbands themselves needed professional help to provide the type of support that might have helped their wives during labor (4). In another study, Gordon et al. (5) found that more than half the laboring women rated the doula as more useful than their husband during labor.

Doctors (e.g. obstetricians and obstetric anesthesiologists), midwives and labor suite nurses work on shift (intermittent contact with a laboring woman) and have a number of direct (clinical) and indirect, non-clinical (e.g. paperwork) patients' care responsibilities, whereas the hall-mark, the sole responsibility of doula care is her continuous, rather than intermittent, presence at the parturient's bedside (2–4). The goal of the medical personnel is to ensure the satisfying and safe outcome, whereas the goal of the doula is to ensure that the woman feels safe and confident throughout labor, birth and the immediate postpartum period.

In the United States, three primary models of doula care have evolved over the past several years. These include: (i) hospital-based doula programs using paid or volunteer doulas, (ii) private practice doula programs, and (iii) community-based doula programs (5). Hospital-based doula programs are funded by grants, hospital budgets or a combination of both. At the University of California, San Diego, the Hearts & Hands (Volunteer) Doula program is primarily supported by grants. In our labor and delivery suite, doula care is offered to anyone, but largely to low-income women, teenage mothers, women laboring alone, incarcerated women and other parturients with special needs (A. J. Fulcher, personal communication).

As doulas acceptance in current obstetric care in hospitals is growing throughout the world, and the doula care is moving quickly as an alternative (yet complementary) addition to medical care during childbirth it is important to recognize the misconceptions, obstacles, controversies and challenges that sometimes arise when new working relationships (e.g. doulas and doctors) are formed. One of the common misconceptions about doula care, which might be of interest to the (obstetric) anesthesiologists, is the common belief that women laboring with an epidural do not need a doula. Interestingly, and surprisingly, not a single article in anesthesiology literature addresses the issue of working relationships (and complementary roles) between anesthesiologists and doulas in the labor and delivery suite.

In conclusion, it should be emphasized that working together, obstetricians and obstetric anesthesiologists, midwives, nurses and doulas can best ensure optimal (medical and non-medical) maternity care for laboring women and provide a safe, satisfying, pain- and stress-free birth experience.

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