

Nurses and Doulas: Complementary Roles to Provide Optimal Maternity Care

Lois Eve Ballen and Ann J. Fulcher

Staff in maternity-care facilities are seeing an increase in doulas, nonmedical childbirth assistants, who are trained to provide continuous physical, emotional, and informational labor support. The long-term medical and psychosocial benefits are well documented. In this article, misconceptions about the doula's role are corrected, and suggestions are offered on ways to improve communication between health care providers and doulas. Together, nurses and doulas can provide birthing women with a safe and satisfying birth. *JOGNN*, 35, 304-311; 2006. DOI: 10.1111/J.1552-6909.2006.00041.x

Keywords: Birth outcomes—Childbirth—Complementary roles—conflict—Doula—Evidenced-based practice—Labor support

Accepted: October 2005

To the relief of some busy nurses, and the consternation of others, trained childbirth assistants called doulas are increasingly present in labor rooms across the United States. In response to the need for one-on-one advocacy and support for a safe and satisfying birth, more and more women are choosing to use doulas, and a rising number of hospitals are developing doula programs. The DONA International, (originally Doulas of North America), one of the largest doula-certifying associations, reports that within its 1st decade, membership grew seven-fold from 750 to 5,221, and the number of doulas certified by DONA increased from 31 to 2,504 during the same period (DONA International, 2005).

However, the role of the doula has not been widely embraced in current obstetric care because of lack of awareness, lack of understanding of the doula's role, and some bad press on interactions between a few

doulas and hospital staff. The purpose of this article is to clarify the positive effects of doula support in labor, clarify some misconceptions about the doula's role, and discuss ways that nurses and doulas can work effectively together.

Benefits of Continuous Labor Support

A growing and unambiguous body of literature demonstrates medical benefits and an increase in patient satisfaction with continuous labor support to both mother and infant and the cost savings to be gained by the use of doulas (Abramson, Altfeld, & Teibloom-Mishkin, 2000; Hodnett, Gates, Hofmeyr, & Sakala, 2003; Sauls, 2002). The Cochrane Library published an updated systematic review on continuous labor support in 2003, concluding "Women who had continuous intrapartum support were less likely to have intrapartum analgesia, operative birth or to report dissatisfaction with their childbirth experiences. Continuous support during labour should be the norm, rather than the exception" (Hodnett et al., 2003).

From the perspective of the health care system, safety is the top priority in childbirth (Miltner, 2002). From the woman's point of view, birth is a life passage in which both safety and satisfaction have great significance (Lavender, Walkinshaw, & Walton, 1999). The woman's perception of her experience is so important that it affects her self-esteem, parenting, breastfeeding skills, and immediate birth outcomes (Kroeger & Smith, 2004; Sauls, 2002). A woman's satisfaction with childbirth is influenced more by the quality of support she receives, feeling in control of herself, and feeling that she was actively involved in decisions than by her degree of pain, the number of interventions she experiences, or even the medical

outcomes (Goodman, 2004; Hodnett, 2002; Lavender et al., 1999). A mother may have an uneventful vaginal delivery and reflect negatively on the experience, or she may suffer complications and consider her birth a satisfying experience. "The goals for all childbearing women are safe, esteem-building, satisfying birth experiences that launch them into motherhood with a sense of competence and self-confidence" (Simkin, p. 7, 2003).

The Role of the Doula

Doulas and Hospital Staff

Traditionally, women birthed with support from other women: a family member or an experienced woman from within the community. Today, this woman is often called a doula; what is different now is how the doula fits into the medical environment. Her role has evolved along with the institutionalization of childbirth and perhaps even because of it. The goal of the nurse is to ensure the safe outcome of childbirth. The goal of the doula is to ensure that the woman feels safe and confident. Knowing the connection among labor and birth experience, a woman's self-esteem, and her medical outcomes (Hodnett et al., 2003; Sauls, 2002), the doula's mandate is to work in tandem with health care staff to support a woman in having a safe and satisfying childbirth experience.

The goal of the nurse is to ensure a safe outcome. The goal of the doula is to ensure that the woman feels safe and confident.

For nurses to value doulas, they must understand what a doula does and does not do and how she complements the nursing care and family support. They must also recognize the beneficial outcomes of doula care. Table 1 outlines the major distinctions between nursing care and doula care.

The doula's sole responsibility is attending to the emotional and comfort needs of a laboring woman and staying by her side continuously throughout labor, birth, and the immediate postpartum period (Klaus, Kennell, & Klaus, 2002). Nurses work on shifts and have clinical responsibilities, paperwork, and may have other patients. The hallmark of doula care is her continuous, rather than intermittent, presence (Klaus et al., 2002; Rosen, 2004; Scott, Berkowitz, & Klaus, 1999).

The doula's care includes direct hands-on physical care and comfort and the use of positioning techniques that

keep the mother comfortable and aid rotation and descent of the baby (Klaus et al., 2002). She keeps the laboring woman informed about her progress in labor and helps the whole family understand each stage (Hodnett, 1996; Klaus et al.). She helps explain medical terminology used by health care staff. If the plan of care changes, the doula facilitates the mother's adjustment to the new plan (Gilliland, 2002; Klaus et al.). She does not speak for or make decisions for the mother or family (Gilliland).

The doula also helps create a satisfying birth memory by making a postpartum visit. Simkin (1991) found that aspects of childbirth that were negative for the woman became more negative over time, whereas positive memories enhanced a woman's long-term self-esteem. The doula allows the woman to reflect on her experience, fills in gaps in her memory, praises her, and sometimes helps her reframe upsetting or difficult aspects of the birth.

Models of Doula Care in the United States

Three primary models of doula care have developed over the past decade: hospital-based programs using volunteer or paid doulas, community-based programs, and private practice doula. Each model of care has advantages and disadvantages.

Hospital-Based Programs. An Internet search quickly uncovers links to several dozens of the more than 100 hospital-based programs in the United States in both private and teaching hospitals and numerous listings for private doula services. The hospital-based program offers doula access to all women. The doulas are familiar with the particular hospital setting, policies, and procedures; the nurses and doulas get to know one another and develop working relationships; and the hospital screens doulas. Disadvantages of the hospital-based model include difficulty maintaining full-time doula coverage, especially if using volunteers, the continual need to recruit and train new doulas, and funding issues to maintain a doula program.

Hospital-based programs are funded by hospital budgets, grants, or a combination of both. University of North Carolina (UNC) BirthPartners, in Chapel Hill, North Carolina, is funded by the Department of Nursing. The University of California (UCSD) Hearts & Hands Volunteer Doula Program in San Diego is primarily grant funded. Both programs use a combination of volunteer scheduled on-call doulas and referral doulas who meet their clients in advance. Doulas are offered to anyone but largely attend underserved mothers including low-income women, teenagers, women laboring alone, incarcerated women, and others with special needs. Since 2000, volunteers have attended over 1,400 births in the in-house Birth Center and the Labor and Delivery Unit at UCSD Medical Center and over 800 births at UNC.

The Cambridge Doula Program in Cambridge, Massachusetts, started in 1995 with seed money from the Boston Foundation. These paid doulas collectively speak 10

TABLE 1***Contrasting the Nursing and Doula Roles***

<i>Role of the Nurse</i>	<i>Role of the Doula</i>
Clinical tasks—vitals, monitoring fetal heart tones and contraction pattern, medications, intravenous access, vaginal examinations, assesses for potential complications.	Supportive role—no clinical functions.
Consults with physician or midwife.	No clinical responsibilities or decisions.
Intermittent presence—leaves for meal breaks, to care for other patients, and at change of shift.	Continuous presence—Leaves patient's room only for bathroom breaks.
May have more than one patient.	Stays with one patient throughout labor and birth.
Keeps patient informed of the progress of labor, explains what is normal, and what to expect.	Keeps patient informed in lay terms of the progress of labor, what is normal, and what to expect.
Advocates by communicating patient's desires to physician or midwife.	Advocates by helping the patient identify her questions and by helping her to communicate with health care staff. Does not offer direction regarding the woman's approach to labor.
Provides intermittent comfort measures and reassurance.	Provides one-on-one, continuous comfort measures and reassurance, including massage and touch, positioning for comfort, and to facilitate fetal rotation and descent.
Documentation responsibilities.	No documentation as part of patient's chart. May keep own records or write "birth stories" for clients.
Has legal responsibility for own actions.	Follows a Code of Ethics; may be certified.
Usually no contact with patient once she is transferred to postpartum unit.	Follow-up postpartum visit, either in the hospital, in-home, or by phone.

to 12 languages. They offer a prenatal visit, attendance at the birth, and up to 15 hours of postpartum care. After seeing the effects of doula care, Cambridge Hospital included funding for the doula program in the annual budget.

Community-Based Programs. Doulas recruited from the community being served offer care that is culturally sensitive because the doula and woman share values and language. Such programs have demonstrated improved outcomes with underserved and high-risk populations, including low-income women, teenagers, and drug users (Abramson et al., 2000). Difficulties may include funding challenges and the doulas' lack of familiarity with the hospital and health care staff.

The Chicago Health Connection (CHC) collaborates with agencies to train doulas recruited from the community being served. In this model, the doula gives extensive support, visiting the woman prenatally, supporting her with birth, and visiting postpartum for up to 12 weeks. The CHC helps other communities adapt the model to varied underserved populations. CoMadres, in rural North Carolina, recruits Spanish-speaking women from within the local Latina community. These doulas meet the pregnant woman prenatally and accompany her to the hospital for her labor, ensuring that the woman has a culturally competent presence.

Doulas in Private Practice. In the private practice model, the birthing woman and her partner have the opportunity to develop a trusting relationship with the doula prior to birth. She is available around the clock, and the relationship may continue after the birth providing postpartum support. The privately hired doula generally spends many hours with the pregnant woman. Contact increases as her due date nears, and the woman has more questions, excitement, and anxiety. The doula is on 24-hour call, attends the entire labor, and follows up with postpartum attention.

The private practice doula is available only to women who can afford to pay for this service, although some insurance companies now reimburse for private doula services (Falcao, R., n.d.). The doula may not be familiar with the nursing staff or the hospital environment, and there may be uncertainty on the part of nurses about whether questions, birth plans, or requests come from the birthing mother or the doula.

Misconceptions About Doula Care

As a modern adaptation of an old idea, doula care is still relatively new and unfamiliar in some maternity-care settings. While many nurses and physicians have nothing but

praise for the doulas in their midst and an increasing number of hospitals have in-house doula programs, controversies and misunderstandings have surfaced as the doula profession gains visibility. A number of misguided assumptions limit recognition of the benefits of doula care.

Misconception 1: Women Laboring With an Epidural Do Not Need a Doula

While the doula's forte is in providing nonpharmacological comfort measures, she also provides valuable care and support for women using analgesics or anesthesia. She provides physical support in early labor and during placement of the epidural and continued informational and emotional support to both the mother and her partner for the rest of the labor and delivery. When women were randomized to receive an epidural or support from a doula along with an epidural if they chose to have one, the cesarean rate was 3.1% in the doula group versus 16.8% in the epidural group. Women in the two groups rated the decrease in their pain level as equivalent whether they received epidural analgesia or were supported by a doula (McGrath & Kennell, 1998).

There are several benefits to having the doula stay with women using epidurals (Simkin, 2003). If the anesthesiologist is not immediately available, the laboring woman's coping skills often diminish as she waits. The doula helps the woman cope while waiting for the epidural and can help her keep a positive perspective if she feels disappointed in herself for opting for medications when she had hoped not to. The doula helps the woman regularly turn from side to side to facilitate fetal rotation and descent, and is available should breakthrough pain arise (Simkin). Once she no longer feels pain, her partner may wish to sleep or leave the room for a meal or break. The doula stays with the laboring woman so she is never alone, and her assistance during pushing, delivery, and recovery remains valuable.

Having a doula present improves medical outcomes, even when a partner is present for labor and birth.

Misconception 2: Women Who Have Supportive Partners Do Not Need Doulas

When asked about the partner's presence, most American women report that the partner's presence increased the meaning of their labor and delivery experience and strengthened their relationship. Even if partners do not participate actively, women view their mere presence as special to birth (Lavender et al., 1999; Mosallam, Rizk, Thomas, & Ezimokhai, 2004). Yet, women ranked dou-

las, midwives, and other family members over their partners in terms of the quality of support they received (*Listening to Mothers survey*, 2003). Numerous studies show that having a doula present improves medical outcomes, even when a partner is present for labor and birth (Gagnon, Waghorn, & Covell, 1997; Hodnett & Osborn, 1989; Kennell & McGrath, 1993).

There are many reasons why partners may feel unable to meet all the needs of a laboring woman. Labor may be a stressful experience if they are uncomfortable in the hospital setting or are uncertain about their support role and the well-being of their partner (Klaus et al., 2002). The doula acts as a role model, showing partners specific ways to help the laboring woman. Many express relief at the prospect of having a doula to share the coaching duties for which they feel unprepared.

Differences between doula and partner behavior have been observed during labor. Bertsh, Nagashima-Whalen, Dykeman, Kennell, and McGrath (1990) showed that doulas stayed within a foot of the woman 85% of the time, while fathers were that close 28% of the time. Doulas spent significantly more time touching the woman (rubbing, stroking, and holding) than partners, whose touching was often limited to hand-holding (Bertsh et al., 1990; Kennell, Klaus, McGrath, Robertson, & Hinkley, 1991).

The doula allows partners to take breaks, provides answers to nonmedical questions, and gives anticipatory guidance regarding what is normal during birth. When comparing the obstetric outcomes of women who birthed with their partner to those who birthed with a partner and a doula, the cesarean rate decreased from 27.9% to 14.7% for those who had the addition of a doula (Kennell & McGrath, 1993).

Misconception 3: Nurses Already Give Labor Support to Birthing Women

The obstetric nurse is familiar with the hospital setting, is already present, and is part of the health care team. However, it is the continuous one-on-one aspect of doula care that has been identified as key to the improved outcomes. Observations of nurses' work patterns have found that nurses spend 6.1% to 31.5% of their time giving support to laboring women. The rest of the time is spent in other patient-related activities such as administering medications, monitoring the mother and baby, documentation, and consulting with physicians or midwives (Gagnon & Waghorn, 1996; Gale, Fothergill-Bourbonnais, & Chamberlain, 2001; Miltner, 2002).

Obstetric nurses who are trained as doulas and provide labor support in addition to their clinical nursing duties have not had the same effect on birth outcomes as when a woman has both a nurse and a doula. "Continuous labor support by nurses had no effect on the cesarean delivery rates or other medical or psychosocial outcomes" (Hodnett et al., 2002). Nurses may not be able to give continuous labor support due to staffing patterns, lack of knowledge

of labor support techniques, or the organizational culture (Rosen, 2004; Sauls, 2002).

The highly technical function of today's clinical nurse lessens her ability to give the type of continuous social support that will impact outcomes. Though many nurses say that they chose their profession out of a desire to care for laboring women, they note that clinical and administrative duties in the current environment preclude their ability to provide such care on a continuous, one-on-one basis. Management of technology, such as electronic fetal monitors, intravenous pumps, and epidurals contributes to distancing nurses from their patients. They are physically removed from the intimate touch that fetoscopes and labor support once involved (Tumblin & Simkin, 2001).

Challenges and Solutions

Controversies and challenges sometimes arise as new working relationships are formed. Given the proven benefits of doula care, there is a need to determine how best to address the problems and develop solutions to incorporate doulas as a valuable and accessible resource.

Challenge 1: Territorialism and Turf

Some nurses have described themselves as "territorial" about their patients, and doulas have reported feeling that there are "turf" issues in the labor rooms, especially when the nurse and doula have not met before. A survey of labor and delivery nurses' perceptions of doulas showed more territorialism when nurses were less experienced in their jobs and had less exposure to doulas. One nurse commented that the doula is helpful if her presence makes the patient less needy; but if the doula questions a lot of things, it is like having two patients. Others have commented that doulas are "taking the fun part of my job" and noted that the doulas and medical providers often "get all the thanks" (O. Swigart, personal communication, November 30, 2005).

In our experience as managers of doula programs, we have seen that success of a hospital-based doula program depends on nurses' exposure to doulas, which helps them understand the doula role. In a tertiary-care teaching hospital in the south, attitudes of the nursing staff were surveyed before and 6 months after a doula program began. During the first 6 months of the doula program, understanding of the doula role and belief that birthing women benefit from doula services increased from 65% to 90% (Ferrari, 2001).

Doulas can be both advocates who help women voice their needs and desires and allies of the medical facility.

Critics of hospital-based doula programs have voiced concern about whether these doulas merely encourage women to accept the routine care given in the hospital or are able to be true patient advocates. As program managers, we have seen that doulas can be both advocates who help women voice their needs and desires and allies of the medical facility.

Challenge 2: Doulas Working Outside of Their Scope of Practice

Nurses have reported feeling that doulas sometimes try to "run the labor," giving medical advice and asserting their own opinions and desires, and that patients sometimes turn more to the doula for recommendations than to the provider or nurse. In January 2004, a front-page article in the *Wall Street Journal* brought to light a growing concern among some doctors and nurses regarding such clashes with doulas (Hwang, 2004).

Sometimes a woman hires a doula hoping she can avoid certain standard protocols and hoping the doula will help forward her agenda. This is not the doula's role. An experienced doula may be instrumental in guiding such women in communicating with their providers, understanding what is negotiable and what is not, or in some cases suggesting they seek a birth setting that better suits their needs or wishes.

Doula associations have standards of practice. The DONA International states that "the DONA-certified doula does not perform clinical or medical tasks such as taking blood pressure or temperature, fetal heart tone checks, vaginal examinations, or postpartum clinical care" (DONA International, 2005). When a doula is acting outside of her defined role, direct discussion and feedback outside of the patient's room may be needed. Nurses should acquaint themselves with avenues available for recourse regarding extreme cases. Professional doula associations have published grievance policies and want to resolve this type of conflict.

Several organizations provide training and certification of doulas. Typically, certification includes observing a child-birth education series; readings ranging from two to eight books; and a 2- to 3-day training workshop or distance learning with a curriculum covering anatomy and physiology of pregnancy and birth, nonclinical comfort measures, and nonpharmacologic pain management methods. Certification has additional requirements, such as evaluations by the client, nurse, and midwife or physician; essays; a written examination; and commitment to a Scope of Practice and Code of Ethics for their doulas. Sources of additional information about doula practice are listed in Table 2.

Benefits of Nurses and Doulas Working Together

Working together, nurses and doulas each play a role in maternal/fetal outcomes. They can even increase each other's

job satisfaction as well as the patient's satisfaction. In addition to her nonclinical care for the laboring woman, the doula can provide an extra pair of hands for busy nurses. Doulas can help the staff by supporting partners and family members during the long hours of labor and often can help with the initiation of breastfeeding.

It has been noted that an experienced nurse has attended many more deliveries than most doulas, but that an experienced doula has observed more continuous hours of labor than many nurses or providers (Gilliland, 2002). If the doula knew the patient prenatally, or has been with the patient during the previous shift, she may have information to share with the nurse about preferences and coping strategies for this particular woman.

Recommendations for Enhancing the Working Relationship

Good two-way communication and mutual understanding of the roles of everyone attending births are important. Guidelines can be developed for staff to address issues related to doulas.

It is helpful if nurses initiate communication with doulas and especially with less-experienced doulas. Introductions outside the labor room should be a standard practice when a doula arrives and at the change of nursing shifts. Whether in private practice or within a hospital-based program, doulas who become familiar to the staff have the advantage of getting to know which of their efforts are most appreciated by the nurses and how to avoid stepping on toes or being in the way. The nurse can clarify with the doula how she can help and what would be considered a hindrance.

Some nurses enjoy the opportunity to teach doulas, especially those interested in studying nursing, midwifery, or medicine. Doulas appreciate guidance, feedback, and especially collaboration. An experienced doula values conversations with staff, which can quickly clear the air if necessary and lead to an atmosphere of collegiality and partnership. Recognizing that doulas have a body of knowledge regarding labor support that complements and that is different from the nurses' knowledge will lead to mutual respect. A team approach allows both nurse and doula to do their jobs well and to best serve the individual birthing mother.

TABLE 2
Resources on Doulas and Labor Support

<i>Major U.S. Associations That Train and Certify Doulas</i>		<i>Organizations and Books for Nurses Regarding Labor Support</i>	
<i>Name</i>	<i>Web Address</i>	<i>Name</i>	<i>Web Address or Source</i>
ALACE (Association of Labor Assistants & Childbirth Educators)	www.alace.org	CIMS (The Coalition for Improving Maternity Services), a collaborative effort of individuals and organizations to promote a wellness model of maternity care to improve birth outcomes and reduce costs.	http://www.motherfriendly.org
CAPPA (Childbirth and Postpartum Professional Association)	www.cappa.net	ANACS (Association of Nurse Advocates for Childbirth Solutions), an association for professional obstetric nurses committed to promoting evidence-based practice and positive birth experiences.	www.anacs.org
DONA International	www.dona.org	<i>The Doula Book: How a Trained Labor Companion Can Help You Have a Shorter, Easier, and Healthier Birth</i> , by Klaus et al. (2002).	Perseus Publishing
ICEA (International Childbirth Education Association)	www.icea.org	<i>The Birth Partner: Everything You Need to Know to Help a Woman Through Childbirth</i> , 2nd edition, by Simkin (2001).	Harvard Common Press.
Lamaze International	www.lamaze.org	<i>The Labor Progress Handbook: Early Interventions to Prevent and Treat Dystocia</i> , by Simkin and Archuleta (2000).	Blackwell Science Ltd.

Conclusions

Doula care is an intervention that complements today's clinical obstetric nursing care. Though the integration of these nonmedical labor assistants into the medical environment has not always been smooth, doula care has been shown to be an evidence-based practice that enhances childbirth outcomes. Understanding, acceptance, and appreciation of each other's roles increase, as health care staff and doulas get to know one another and develop working relationships.

Continued research on the effects of doula care in the current medical environment and the long-term effects of doula care on parenting and breastfeeding would be beneficial. Studies are also needed to determine the models of doula care that are most effective in specific settings and the approaches that best blend doula care into standard obstetric care.

In the meantime, doula care should be an option for all birthing women. Childbirth is not simply a medical event. The type of care a woman receives is as important as the medical outcomes. Pregnancy, childbirth, and parenting are all part of the life continuum, and how support is provided for each of these is perhaps a mark of any culture's advancement.

REFERENCES

- Abramson, R., Altfeld, S., & Teibloom-Mishkin, J. (2000). The community-based doula: An emerging role in family support. *Zero to Three*, October/November 11-16.
- Bertsh, T. D., Nagashima-Whalen, L., Dykeman, S., Kennell, J. H., & McGrath, S. K. (1990). Labor support by first-time fathers: Direct observations with a comparison to experienced doulas. *Journal of Psychosomatic Obstetrics and Gynaecology*, 11, 251-260.
- DONA International (n.d.) Member Statistics. Retrieved September 12, 2005, from <http://www.dona.org/aboutus/statistics.php>
- DONA International (n.d.) Standards of Practice for Birth Doulas. Retrieved September 25, 2005, from http://www.dona.org/aboutus/standards_birth.php
- Falcao, R. (n.d.) Money and Paperwork. Retrieved September 25, 2005, from <http://www.gentlebirth.org/archives/money.html#Doula> <http://www.gentlebirth.org/archives/money.html>.
- Ferrari, R. (2001). *UNC Birthpartners: An assessment of the initial stages of implementation*. Unpublished Summer Field Placement of MPH Candidate.
- Gagnon, A. J., & Waghorn, K. (1996). Supportive care by maternity nurses: A work sampling study in an intrapartum unit. *Birth*, 23, 1-6.
- Gagnon, A. J., Waghorn, K., & Covell, C. (1997). A randomized trial of one-to-one nurse support of women in labor. *Birth*, 24, 71-77.
- Gale, J., Fothergill-Bourbonnais, F., & Chamberlain, M. (2001). Measuring nursing support during childbirth. *American Journal of Maternal Child Nursing*, 26, 264-271.
- Gilliland, A. L. (2002). Beyond holding hands: The modern role of the professional doula. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 31, 762-769.
- Goodman, P. (2004). Factors related to childbirth satisfaction. *Journal of Advanced Nursing*, 46, 212-219.
- Hodnett, E. D. (1996). Nursing support of the laboring woman. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 25, 257-264.
- Hodnett, E. D. (2002). Pain and women's satisfaction with the experience of childbirth: A systematic review. *American Journal of Obstetrics & Gynecology*, 186, S160-S171.
- Hodnett, E. D., Gates, S., Hofmeyr, G. J., & Sakala, C. (2003). Continuous support for women during childbirth. *The Cochrane Database of Systematic Reviews* 2003, 3, CD003766.
- Hodnett, E. D., Lowe, N. K., Hannah, M. E., Willa, A. R., Stevens, B., Weston, J. A., et al. (2002). Effectiveness of nurses as providers of birth labor support in North American hospitals: A randomized controlled trial. *JAMA*, 288, 1373-1381.
- Hodnett, E. D., & Osborn, R. W. (1989). Effects of continuous intrapartum professional support on childbirth outcomes. *Research in Nursing & Health*, 12, 289-297.
- Hwang, S. (2004). Mother's helper: As "doulas" enter delivery rooms, conflicts arise. *The Wall Street Journal*, CCXLIII, pp. A1, A10.
- Kennell, J. H., Klaus, M. H., McGrath, S. K., Robertson, S., & Hinkley, C. (1991). Continuous emotional support during labor in a US hospital: A randomized controlled trial. *Journal of the American Medical Association*, 266, 2197-2201.
- Kennell, J. H., & McGrath, S. K. (1993). Labor support by a doula for middle-income couples: The effect on cesarean rates. *Behavioral Pediatrics*, 33, 12A.
- Klaus, M. H., Kennell, J. H., & Klaus, P. H. (2002). *The doula book; how a trained labor companion can help you have a shorter, easier, and healthier birth*. Cambridge, MA: Perseus Publishing.
- Kroeger, M., & Smith, L. J. (2004). *Impact of birthing practices on breastfeeding: Protecting the mother and baby continuum*. Sudbury, MA: Jones and Bartlett.
- Lavender, T., Walkinshaw, S. A., & Walton, I. (1999). A prospective study of women's views of factors contributing to a positive birth experience. *Midwifery*, 15, 40-46.
- Listening to Mothers survey*. (2003). Retrieved October 10, 2004, from http://www.maternitywise.org/prof/laborsupport/LtM_body.html
- McGrath, S. K., & Kennell, J. H. (1998). Induction of labor and doula support. *Pediatric Research*, 43, 13A.
- Miltner, R. S. (2002). More than support: Nursing interventions provided to women in labor. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 31, 753-761.
- Mosallam, M., Rizk, D. E., Thomas, L., & Ezimokhai, M. (2004). Women's attitudes towards psychosocial support in labour in United Arab Emirates. *Archives of Gynecology and Obstetrics*, 269, 181-187.
- Rosen, P. (2004). Supporting women in labor: Analysis of different types of caregivers. *Journal of Midwifery & Women's Health*, 49, 24-31.
- Sauls, D. J. (2002). Effects of labor support on mothers, babies, and birth outcomes. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 31, 733-741.

- Scott, K. D., Berkowitz, G., & Klaus, M. H. (1999). A comparison of intermittent and continuous support during labor: A meta-analysis. *American Journal of Obstetrics and Gynecology*, 180, 1054-1059.
- Simkin, P. (2003). Emotional support for the woman w/an epidural. *International Journal of Childbirth Education*, 18, 4-7.
- Simkin, P. (2001). *The Birth Partner: Everything You Need to Know to Help a Woman Through childbirth* (2nd ed.). Boston, MA: Harvard Common Press.
- Simkin, P. and Archuleta, R. (2000). *The Labor Progress Handbook: Early Interventions to Prevent and Treat Dystocia*. Oxford, UK: Blackwell Science Ltd.
- Simkin, P. (1991). Just another day in a woman's life? Women's long-term perceptions of their first birth experience. Part 1. *Birth*, 18, 203-210.
- Tumblin, A., & Simkin, P. (2001) Pregnant women's perceptions of their nurse's role during labor and delivery. *Birth*, 28, 52-56.
- Lois Eve Ballen, RN, CNM, MSN, IBCLC teaches nursing at Durham Technical Community College and is Program Manager of UNC BirthPartners, Volunteer Hospital-Based Doula Program, at University of North Carolina, Chapel Hill, NC.*
- Ann J. Fulcher, CD, CLE, is a program manager of the UCSD Hearts & Hands Volunteer Doula Program, University of California, San Diego (UCSD) Medical Center.*
- Address for Correspondence: Lois Eve Ballen, RN, CNM, MSN, IBCLC, 2 West Haven Place, Durham, NC 27705. E-mail: Lballen@unch.unc.edu or Loballen@earthlink.net*