How Birth Doulas Help Clients Adapt to Changes in Circumstances, Clinical Care, and Client Preferences During Labor

Natalie Lea Amram, BSc
Michael C. Klein, MD, CCFP, FAAP (Neonatal–Perinatal), FCFP, ABFP, FCPS
Heidi Mok, RM, MSc
Penny Simkin, PT
Kathie Lindstrom, CD(DONA), BDT(DONA), LCCE, FACCE
Jalana Grant, CD(DONA), BDT(DONA), LCCE

ABSTRACT

This study examined how doulas adapt to challenges in client's labors. There were 104 Canadian and 92 American doulas who responded to a survey distributed at a doula conference. We report results from open-ended questions in which doulas describe how they manage changes deviating from the mother's birth plan and how they navigate differences of opinion between themselves and providers. Four themes emerged: giving nonjudgmental support, assisting informed decision making, acting as a facilitator, and issues with advocacy. Although 30% of doulas said that advocacy and information giving could result in conflict with providers, doulas reported working within their scope of practice and striving to be part of the team. Issues in doula responsibility and patient advocacy remain, and ongoing role clarification is needed.

The Journal of Perinatal Education, *23*(2), 96–103, http://dx.doi.org/10.1891/1058-1243.23.2.96
Keywords: doula, interprofessional relations, role, caregiver

Doulas have been in the process of integrating into the maternity care system for the last 30 years. Doulas are trained to provide continuous support, give comfort measures, and help their clients make informed decisions. Research, coming mainly from underserved populations, shows that doulas have a positive influence on labor and birth outcomes, such as shortening the length of labor, lowering the rate of epidural use, and lowering the rate of cesarean surgery (Scott, Berkowitz, & Klaus, 1999). Mothers supported by doulas have demonstrated more affectionate interactions with their newborns, less anxiety, and felt the doula had a positive influence on their birth experience (Scott, Klaus, & Klaus, 1999).

Although it has been suggested that collaborative care by doulas positively impacts the mother's perception of her birth, interprofessional tension can result in a negative experience (Gilliland, 2002; Papagni & Buckner, 2006). In fact, it is not unusual to find conflict between maternity care providers and

doulas (Eftekhary, Klein, & Xu, 2010; Lantz, Low, Varkey, & Watson, 2005; Stevens, Dahlen, Peters, & Jackson, 2011). Lantz et al. (2005) suggested that some interprofessional conflict would be expected as doulas evolve as a new maternity care discipline. Many authors have suggested that tension between practitioners and doulas is likely because of overlap in roles (Ballen & Fulcher, 2006; Gilliland, 1998; Lantz et al., 2005; Stevens et al., 2011) or when some doulas work outside their scope of practice by giving medical advice (Ballen & Fulcher, 2006; Gilliland, 1998, 2002; Papagni & Buckner, 2006; Stevens et al., 2011). In rare cases, doulas have been asked to leave the labor room (Eftekhary et al., 2010).

Given the evolving role of doulas in maternity care, it is important to discover how doulas interpret and adhere to their scope of practice. Recognizing these issues of scope and content of doula practice, the objectives of this study were (a) to determine how doulas work or fail to work within their scope of practice and (b) how doulas manage conflict and whether they contribute to tension between providers and clients.

METHODS

Study Design and Population

The overall study used a mixed methods approach intended to investigate the demographics, practice styles, beliefs, and attitudes of North American doulas. Three open-ended questions were designed to gain insight into how doulas remain compliant with their standards of practice while handling challenges during the labor and birth.

This study was based on a convenience sample of North American doulas attending the DONA International (formerly Doulas of North America) Conference in Vancouver in 2008. The survey instrument was a paper survey, which had been developed based on the existing literature (Eftekhary et al., 2010; Klein et al., 2009; Lantz et al., 2005). The close-ended questions dealt with demographics, details of birth doula services, and practice style. The open-ended questions explored how doulas managed interventions that depart from the client's original birth plan and methods that doulas might use that could result in problems with clients or care providers (Table 1). The University of British Columbia Behavioural Research Ethics Board approved the study.

TABLE 1
Open-Ended Questions

1. Please explain how you handle choices made during labor by *your client* that depart from her original birth plan/wishes.
2. Please explain how you handle interventions initiated by your client's *care provider* that depart from your client's birth plan/wishes during labor.
3. Please explain qualities/actions that you bring to laboring women/families that may be problematic or result in challenges with your clients and/or their care provider(s).

Analysis

This article reports on only the open-ended or qualitative aspects of the survey using the philosophical perspective of phenomenology, an approach designed to gain insight into people's lived experiences and feelings (Rees, 2003). Open-ended questions gave doulas the opportunity to fully express themselves and show the dynamic ways doulas deal with challenges.

Thematic analysis allowed researchers to recognize patterns, identify emerging themes, and analyze the identified patterns and life experiences. Two coders read and analyzed the responses independently a minimum of four times. Only themes found by both coders were used in the analysis. Multiple readings ensured validity. Both coders quantified the frequency of coded themes and selected those occurring most often for discussion. One coder was both a doula and student midwife and the other a registered academic midwife. Multiple readings of the responses and repeating coding throughout the analysis ensured reliability. Interrater reliability and validity was enhanced by having the two coders possessing a range of doula knowledge yet independently discovering the same themes (Boyatzis, 1998).

RESULTS

There were 376 doulas who attended the DONA International Conference; 196 responded to the survey, generating a response rate of 52.1%. Of the respondents, 53.1% were Canadian and 46.9% were American. Table 2 shows that Canadian and American doulas were similar in age, relationship status, and previous personal birth experience. They were a highly educated sample. Canadian doulas worked somewhat fewer years than American doulas. Ninety-three percent of Canadian and 88% of American doulas had formal DONA birth doula training, with 18% and 25% respectively having birth doula training from organizations other than DONA, many in addition to their DONA training. However, because we found that the responses and characteristics of doulas from the United States

TABLE 2
Doula Demographics

	Canada	USA	
	N (%)	*N* (%)	
	104 (53.1)	92 (46.9)	*p*
Age—*M* (*SD*)	39.6 (10.9)	40.5 (11.1)	.544
Married/in a long-term relationship	96 (93.2)	79 (85.9)	.092
Given birth	90 (86.5)	73 (79.3)	.179
Years have you been working as a doula—*M* (*SD*)	5.1 (5.2)	7.7 (7.3)	.005
Additional education			
Birth doula training (DONA)	97 (93.3)	81 (88)	.206
Other birth doula training	19 (18.3)	23 (25.0)	.252
What is the level of your education?			
Some high school	1 (1.0)	0	N/A
High school graduate	5 (4.8)	7 (7.7)	
Some postsecondary	24 (23.1)	17 (18.7)	
Postsecondary certificate or diploma	45 (43.3)	9 (9.9)	
Bachelor's degree	18 (17.3)	28 (30.8)	
Above bachelor's degree	11 (10.6)	30 (33.0)	

and Canada were so similar, we merged the results. Hence, the themes identified can be viewed as representing the core issues and values identified by North American doulas.

Four themes emerged from the analysis of the open-ended questions: giving nonjudgmental support, assisting informed decision making, acting as a facilitator, and issues with advocacy. In each section, responses selected were representative of the theme. Each response emanated from a different doula.

Giving Nonjudgmental Support

Nearly half of all doulas reported that their response to unexpected or undesired interventions that arose during labor was to provide nonjudgmental support to their clients, even when they might disagree with the decision undertaken by the provider or mother. Doulas reported that they felt bound to show respect for and honor the client's choices over the doula's personal biases or beliefs about birth. Many doulas emphasized that, as one doula wrote, their "support isn't dependent on [their client's] choices." Another doula described nonjudgmental support as, "With utmost respect and understanding, the birth is *her* journey . . . remembering this is all about her, her body and what she wants. My stuff and my needs don't count here."

Doulas also highlighted emotional support as a key part of their care, especially when interventions occurred that were not part of the woman's original birth plan. Being aware of the woman's emotions guided the doula to match her support to the woman's feelings. It also helped the woman to stay present in her birth experience and, later, to process it. One doula wrote:

> *When appropriate (timing is everything), I would ask my client how she/they are feeling about the changes. Is this a surprise? Is this a relief? I listen to not only the words. I would follow my client's lead—if she were really upset—I would calm her in any way I could . . . I would validate their feelings while exploring the reasons for the intervention if it were apparent to me. I would be available for debriefing after the birth.*

Assisting Informed Decision Making

When unexpected interventions are proposed by the care provider, three quarters of doulas reported that an important aspect of their role was to assist the client in making informed choices. Most doulas described creating space for the clients in the informed decision-making process by prompting them to become engaged in the conversation. One doula explained:

> *If I don't hear my client or their partner speak up, I turn to them and ask, "Did you want to know anything about that procedure?" or "Do you want to talk about [the intervention] or "Do you have any questions I can answer for you?" Hopefully that gets them thinking and [lets them] be a part of the decision-making process with all the information they need.*

Some doulas reported that they facilitated an informed choice discussion by giving or offering information directly to the woman. Although these doulas felt that they were not giving medical advice or opinion, they felt it was within their role to lead the discussion. Some doulas replied that they might ask for some private time with the client, during which a discussion of the benefits and risks of the procedure took place. One doula wrote, "I explain the pros, cons, alternatives, and options to my clients to help them decide how they want to handle [the intervention], [making] sure parents are fully informed in their decision."

However, other doulas felt that it was not their place to give information. They would instead direct

their client to the care provider for a full discussion. For example, this doula described how she guided her client: "I try to encourage my client to speak directly to the care provider by asking questions if necessary—for example, 'The care provider is going to break your water, do you have any questions?'"

Although 98% of doulas reported that they met their clients at least once prenatally, only 15% described using their prenatal meetings as a key part in assisting in informed decision making. In cases where the doula was able to meet with the client prenatally, the birth plan was examined and then discussions of how to deal with unexpected interventions provided an opportunity for the doula to learn about the client's preferences and provide information on benefits, risks, and alternatives to common decision points in labor. One doula wrote, "I believe it is important to empower the client by discussing possible interventions with them before labor. During this time I try to prepare them by giving them tools to discuss various interventions."

Acting as a Facilitator

Because circumstances in birth often deviate from the birth plan, sometimes, it is the care provider who proposes interventions that were not part of the mother's plan. Other times, it is the mother herself who chooses a different course of care than her original wishes. Doulas described various facilitative techniques in these circumstances. Before making a final decision about interventions, many doulas reported they were guided by the client's prior wishes. A third of doulas discussed using the birth plan as a reminder for everyone that the mother had expressed specific hopes for her birth. In this way, the birth plan also acted as a tool to identify where the change was coming from and to see if the mother needed further support. One doula explained, "I remind her of her original plan, why they chose what they did, and explore why she is choosing something different."

Reminding parents of the birth plan also acted as a jumping point for enhancing communication with the care provider. It alerted the care provider of the mother's original wishes or created space to allow the woman to speak up. This doula described how she used the woman's birth plan to facilitate communication with the care provider:

> *I try to ask my client in the presence of her care provider, things like "I know it was important for you to avoid (pain meds, episiotomy, etc.). You have a right to choose. Do you need time to discuss this? Is there anything you want to say to your care provider?"*

A minority of doulas described offering alternatives when a woman's birth is not following her plan. For example, if the client had desired to avoid pain medications but now in actual labor doubted her ability to do without them, doulas reported laying out options, such as waiting for an hour or a few contractions. One doula described how offering choices was a way to distinguish a client dealing with a challenging moment from a client who was truly suffering: "I ask [if she] wants to try the tub, shower, or walk first. I really listen to how she is coping."

Doulas reported how they helped their clients to be flexible rather than stick rigidly to a plan. Some doulas encouraged this by prenatally discussing with the mother how to shift her focus to working with the actual labor in the moment rather than imaging that they could plan for the unpredictability of labor and birth in every detail. These doulas felt that a mother being continually involved in her own care as the labor unfolded would lead to the mother feeling empowered by her own choices. One doula described her experiences doing this as "I really work with clients beforehand [so as] not be attached to certain outcomes but [rather to be] involved in the outcome through active participation and encourage confidence in their wishes." Doulas reported recognizing that often, labors do not go as expected and that they need to be ready to modify their support when the mother deviated from her birth plan. By reading the mother's subtle signs and cues, doulas expressed that they were able to respond to the flow of each labor and each woman. This doula said that by getting to know her clients, she was able to adapt to their needs and facilitate their transitions in the labor process:

> *This can be challenging as we can't know or plan how everything will evolve, so I try to constantly be aware what is in line with her ever-evolving birthing journey and instincts and the necessary departure [from the plan] and how she may be needing my support.*

Another important aspect of facilitation was to ensure that the client understood what was going on. Some doulas described that by engaging the client in realistic discussions, they were able to help put the client back in control while ensuring the mother remained an active participant in her own care. One doula explained, "I ask if she feels ok and understands the reason that [the intervention] is being offered. I help them feel that they're

Doulas described a struggle between balancing their personal knowledge, obligation to respect client's wishes, and also the need to work within a team and create a nonthreatening environment.

part of the choice being made and [are] on board with the change . . . so it actually becomes their choice."

Last, one quarter of doulas stated that a crucial part in facilitation was to create space by requesting time alone or by asking the provider for a pause in the proceedings. It allowed for women to have sufficient time to think about their decision, get information, and realign their birth plan. This doula wrote, "I ask for time to discuss with my client so that we can have the facts and my client can feel free to ask for more information and make the decisions for herself."

Issues With Advocacy

Most doulas felt that it was within their role to advocate for the client and to ensure their client's preferences were heard. Although a doula can remind or prompt her client, it is not part of the doula's role to speak directly to the care provider, although some experienced doulas do so, using some of the techniques outlined earlier. Some doulas were confident that they had appropriate ways to incorporate the care provider into the discussion; others were not. However, not all situations are clear, and advocacy can become challenging. Many doulas emphasized that their role was not to personally or directly communicate with care providers but to help the mother and partner speak for themselves. One doula highlighted this issue:

> *I quietly remind the couple about the impending deviation from the plan. I believe it is the woman and her partner's responsibility to speak up to the caregiver if they need to discuss any aspect of their care. I can give her the research info, discuss decisions, and alternatives, but I cannot be her voice. She must do that.*

Other doulas described how they enhanced communication with care providers by encouraging the woman to speak for herself or by reminding the mother and her partner to have a discussion with the care provider about any concerns. This doula described that by facilitating communication, she helped bridge the caregiver's concerns with the woman's hopes:

> *I believe it is important to give [the client] tools to help them talk with their caregiver. It is important to create an atmosphere of collegiality during birth so I try to help my clients be cognizant of the caregiver's advice while keeping their own wishes possible.*

Rarely did doulas describe discussing options with the care provider directly, but when they did, there was often a context as to why—for example, with a less articulate client or one in severe pain. However, overall, the responses indicated that most doulas did not directly offer their opinion to providers:

> *I make certain—as much as possible—that the clients have time to consider and ask questions of their provider, sometimes by my asking questions [of the provider] as if I don't know, so that a less responsive client can hear and begin to formulate her own questions. I make no decisions nor offer my opinion during this time.*

Especially when considering facilitation and advocacy, it is clear that the doula's role itself can be problematic. Respondents expressed concern that a doula's support and encouragement could be perceived as challenging of caregiver advice. Nearly one-third of doulas acknowledged that giving information to clients could be perceived as oppositional to some health-care providers. One doula described this issue: "I'm uncertain how to handle a situation when the caregiver 'corners' my client—I feel I should be more assertive in reminding my clients of their original plan, but I don't want to come across as challenging their caregiver."

These doulas described a struggle between balancing their personal knowledge, obligation to respect client's wishes, and also the need to work within a team and create a nonthreatening environment. They sometimes felt they were in a "catch-22": They knew it was within their role to ensure their client understood and had information, but believed that giving information during the birth made the staff feel that the doulas were opposing them. When clients asked questions, or made choices that differed from what the care provider suggested, the provider might attribute the client's decision to the doula and the doula might be accused by the provider of interfering in his or her professional care: "I work really hard to avoid all problems with clients and their caregivers. Sometimes caregivers 'credit' me with the decisions my clients make. I feel misunderstood and that by 'empowering' women to ask questions, I create this."

The effort to be perceived as nonconfrontational could sometimes influence the way doulas gave supportive care. This minority of doulas felt intimidated by a perceived need to conform to hospital staff's wishes or rules, even when they knew an intervention was against a client's wishes or even non–evidence

based. One doula described that she would stay on neutral ground to create relationships with staff:

> *I sometimes get flustered and let care providers change the way I support a family—especially when I am working with a new care provider who doesn't yet trust me or understand what I do. It's hard to not to be wanted on the team.*

DISCUSSION

This study explored how doulas help clients adapt to changes in the circumstances of labor and birth from the clients' idealized birth plan. Giving nonjudgmental support, assisting with informed decision making, and acting as a facilitator are cornerstones of doula care and strongly express the shared values of doulas. These themes and values are also found in other studies emanating from various physical and attitudinal environments (Akhavan & Lundgren, 2012; Gilliland, 2002, 2011; Koumouitzes-Douvia & Carr, 2006; Stevens et al., 2011).

In our study and other publications, the responses reflected the training and standards of practice of DONA-trained doulas (DONA International, 2005). The doula's role is informative and supportive, ensuring the client is given the opportunity to make decisions while empowering clients in their choices (Ballen & Fulcher, 2006; Gilliland, 2002). Our theme of nonjudgmental support is echoed in the literature, showing that supporting clients in a nonjudgmental way and by maintaining a continuous presence, mothers feel more positive about their choices and their birth (Akhavan & Lundgren, 2012; Gilliland, 2011; Koumouitzes-Douvia & Carr, 2006).

There is an interesting shift that occurred when doulas confronted a provider-initiated change from the birth plan. When the care provider requested a change, the focus of the doula became ensuring the client understood the change while creating the opportunity for clients to become involved in an informed decision-making process. However, when it is the mother who requests a change from the plan, the doula first confirms and then supports the change. All of these strategies assisted in putting the clients back in control by guiding clients to make their own choices and allowing for more positive feelings about change (Gilliland, 2002). Simkin (1992) found births happening with the mother, rather than to her, lend themselves to positive birth memories.

Another cornerstone identified both by study respondents and within the standards of practice (DONA International, 2005) is that of advocacy. Our study results show that in their role as advocates, doulas are generally functioning within the DONA standards of practice (2005). Many respondents understood that their role is to facilitate communication between the mother and her care provider and not to speak directly to providers. However, careful reading of the responses showed that what some doulas consider to be nonmedical or nonprofessional advice or questioning could, by some care providers, be considered as medical interference.

Some responses demonstrated an appreciation that advocacy can result in conflict, thereby explaining why some doulas are perceived as behaving inappropriately—*because* information giving may be interpreted as challenging to care providers. Doulas reported feeling that some staff thought the information they gave clients was in conflict with hospital policy or the care given by providers. Although Lantz et al. (2005) and Gilliland (2002) saw the potential for "challenges to team members' relative authority and expertise," this study documents that these challenges are real.

Doulas often feel blamed when an informed choice discussion results in a client rejecting a care provider's suggestion. Our study responses did not clarify whether this tension was the result of the care provider's failure to appreciate that the doula's role is to provide information or whether tension arose from *how* doulas present information. There is an unavoidable and inherent conflict in role dynamics because it is the primary role of both the care provider and the doula to provide information. When a doula gives information that indicates the provider's suggestion is not evidence-based, or that the provider is not giving all the options, it can set up conflict. This is especially true when the doula and the provider are operating in different value systems or if there is conflict with what the evidence shows.

Another reason why providers might feel negativity toward doulas arises from the type of client that chooses to have a doula. Some couples who have experienced a "bad birth" from an outcome or process-related reason may choose a doula in hope that she will protect from a repeat of that experience. Such clients are often very guarded and have strong, even nonnegotiable feelings about what they would like to avoid in labor (Gilliland, 1998, 2002; Klein, 1983).

Doulas also described an inner conflict because they know from the literature and from experience that some interventions inevitably create problems or begin a cascade of interventions. Although doulas appreciate that they have personal biases, and know

that these biases need to be controlled, in their role of advocate, they can feel conflicted when the provider seems to be doing something not discussed, non–evidence-based, or is in conflict with the client's values. Sometimes, this conflict is compounded by a frustration with the birthing system itself and the futility of having to bear witness to the expected cascade of interventions that might have been prevented. Perhaps paradoxically, despite this struggle and the intrinsic inevitable role conflicts, doulas reported that they feel they strive to come across as unchallenging.

Some doulas felt intimidated by the responsible care providers, acknowledging that there are often politics and unachievable expectations surrounding birth, forcing doulas to change how they support a family to maintain relationships with staff for this birth and future births. Simply put, the doula may make decisions about what to say and how to say it based on her ability to be accepted in the future within a challenging institution. Rarely, this theoretically could be a decision that is not in the best interest of a particular client.

Doulas understand that creating a battleground to prevent unnecessary interventions is not appropriate. Only one doula described openly expressing her disagreement with a caregiver, and another acknowledged that she offered opinions about a woman's medical care during the birth. Because information giving and advocacy are areas where values and professional roles collide, they invite potential breakdown of communication in the labor room. Mothers may be unclear about how much a doula can advocate on their behalf, some doulas may not be clear about strategies to engage the care provider, and care providers may not understand the doula's role.

Role confusion and differential information sharing are areas that are challenging in the service of establishing a harmonious birthing environment. Care providers sometimes see doulas as challenging their authority, although conversely, doulas perceive their support of clients as helpful in informed decision making (Gilliland, 2002; Lantz et al., 2005). There is also an apparent lack of understanding among some doulas about how to smoothly navigate these relationships and to build bridges between care providers, doulas, and laboring families—particularly when supporting a woman in a nonsupportive setting or system.

There are, however, some remedies at hand. Ballen and Fulcher (2006) showed that successful integration and understanding of a doula in her role is dependent on exposure to other doulas. Familiarity with the "hospital's protocols or how to communicate effectively in a medical setting" are learned skills that come with attending many births (Gilliland, 2002). This area of role conflict is predictable and normal, considering doulas are the "new kid on the block."

More recent data from the *Canadian National Study of Attitudes and Beliefs* of both providers (Klein et al., 2009; Klein, Kaczorowski, Tomkinson, et al., 2011; Klein, Liston, et al., 2011) and the women they serve (Klein, 2011; Klein, Kaczorowski, Hearps, et al., 2011) has shown that providers have mixed feeling about doulas. Many Canadian women approaching their first birth also were unclear on the role of doulas (Klein, Kaczorowski, Hearps, et al., 2011). This study provides some information as to why these attitudes and conflicts exist and hopefully can set the stage for the needed dialogue on roles and responsibilities.

LIMITATIONS

Limitations were caused by the survey format, because responses were limited to what was reported and the authors were unable to follow up with the respondents. Although some of our results are represented as proportions, there is some debate about the appropriateness of presenting information in this way for a qualitative study. The results of this study may or may not be representative of what doulas actually do in the field. As well, this survey was given at a DONA conference where nearly all doulas had formal DONA training. The results of this study cannot be extended to self-styled doulas without training or those certified by other certification bodies.

CONCLUSION AND IMPLICATIONS FOR PRACTICE

This study demonstrates that DONA-trained doulas are using many techniques to assist couples to integrate changes in the birth process that deviate from the client's plan. DONA doulas appear to be acting in accordance with their standards of practice. This study shows that there are almost inevitable conflicts that evolve from the intrinsic role overlap between care providers and doulas. Whether and how these conflicts will or will not be actualized is another area for study. When doulas provide their clients with information, this can be perceived as in conflict with the role of care providers. For optimum care and outcome, it is essential that all players accept and respect each other's unique roles. To achieve this, education of all health-care professionals is necessary so that the doula's role and scope of practice is clearly understood.

ACKNOWLEDGMENTS

The authors wish to thank all the participants of the study; the DONA International board for supporting the survey at the conference; Aoife Chamberlaine for her foundational work with the study; and Stephen Hearps, Jocelyn Tomkinson, and Colleen Fulton for their support and extensive assistance without whom this research would not be possible.

REFERENCES

Akhavan, S., & Lundgren, I. (2012). Midwives' experiences of doula support for immigrant women in Sweden—A qualitative study. *Midwifery*, *28*(1), 80–85.

Ballen, L. E., & Fulcher, A. J. (2006). Nurses and doulas: Complementary roles to provide optimal maternity care. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, *35*(2), 304–311.

Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. Thousand Oaks, CA: Sage.

DONA International. (2005). *Standards of practice for birth doulas*. Retrieved from http://www.dona.org/aboutus/standards_birth.php

Eftekhary, S., Klein, M. C., & Xu, S. (2010). The life of a Canadian doula: Successes, confusion, and conflict. *Journal of Obstetrics and Gynaecology Canada*, *32*(7), 642–649.

Gilliland, A. L. (1998). Commentary: Nurses, doulas and childbirth educators—Working together for common goals. *The Journal of Perinatal Education*, *7*(3), 18–24.

Gilliland, A. L. (2002). Beyond holding hands: The modern role of the professional doula. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, *31*(6), 762–769.

Gilliland, A. L. (2011). After praise and encouragement: Emotional support strategies used by birth doulas in the USA and Canada. *Midwifery*, *27*(4), 525–531.

Klein, M. C. (1983). Contracting for trust in family practice obstetrics. *Canadian Family Physician*, *29*, 2225–2227.

Klein, M. C. (2011). Many women and providers are unprepared for an evidence-based, educated conversation about birth. *The Journal of Perinatal Education*, *20*(4), 185–187.

Klein, M. C., Kaczorowski, J., Hall, W. A., Fraser, W., Liston, R. M., Eftekhary, S., . . . Chamberlaine, A. (2009). The attitudes of Canadian maternity care practitioners towards labour and birth: Many differences but important similarities. *Journal of Obstetrics and Gynaecology Canada*, *31*(9), 827–840.

Klein, M. C., Kaczorowski, J., Hearps, S. J., Tomkinson, J., Baradaran, N., Hall, W. A., . . . Fraser, W. D. (2011). Birth technology and maternal roles in birth: Knowledge and attitudes of Canadian women approaching childbirth for the first time. *Journal of Obstetrics and Gynaecology Canada*, *33*(6), 598–608.

Klein, M. C., Kaczorowski, J., Tomkinson, J., Hearps, S., Baradaran, N., & Brant, R. (2011). Family physicians who provide intrapartum care and those who do not: Very different ways of viewing childbirth. *Canadian Family Physician*, *57*(4), e139–e147.

Klein, M. C., Liston, R., Fraser, W. D., Baradaran, N., Hearps, S. J., Tomkinson, J., . . . Brant, R. (2011). Attitudes of the new generation of Canadian obstetricians: How do they differ from their predecessors? *Birth*, *38*(2), 129–139.

Koumouitzes-Douvia, J., & Carr, C. A. (2006). Women's perceptions of their doula support. *The Journal of Perinatal Education*, *15*(4), 34–40.

Lantz, P. M., Low, L. K., Varkey, S., & Watson, R. L. (2005). Doulas as childbirth paraprofessionals: Results from a national survey. *Women's Health Issues*, *15*(3), 109–116.

Papagni, K., & Buckner, E. (2006). Doula support and attitudes of intrapartum nurses: A qualitative study from the patient's perspective. *The Journal of Perinatal Education*, *15*(1), 11–18.

Rees, C. (2003). *Introduction to research for midwives*. Edinburgh, United Kingdom: Books for Midwives.

Scott, K. D., Berkowitz, G., & Klaus, M. (1999). A comparison of intermittent and continuous support during labor: A meta-analysis. *American Journal of Obstetrics and Gynecology*, *180*(5), 1054–1059.

Scott, K. D., Klaus, P. H., & Klaus, M. H. (1999). The obstetrical and postpartum benefits of continuous support during childbirth. *Journal of Women's Health and Gender Based Medicine, 8*(10), 1257–1264.

Simkin, P. (1992). Just another day in a woman's life? Part II: Nature and consistency of women's long term perceptions of their first birth experience. *Birth*, *19*(2), 64–81.

Stevens, J., Dahlen, H., Peters, K., & Jackson, D. (2011). Midwives' and doulas' perspectives of the role of the doula in Australia: A qualitative study. *Midwifery*, *27*(4), 509–516.

NATALIE LEA AMRAM *has been a birth doula since 2008. She is now a registered midwife in Vancouver.* MICHAEL C. KLEIN *is a family physician, pediatrician, neonatologist, and maternity care researcher. He has authored more than 150 peer-reviewed articles and is best known for his landmark randomized controlled trial (RCT) of episiotomy that demonstrated that routine episiotomy caused the very problems it was supposed to prevent.* HEIDI MOK *is a registered midwife originally from the United Kingdom. She now practices as a midwife in British Columbia and is a clinical faculty in the Midwifery Department of the University of British Columbia.* PENNY SIMKIN *is a physical therapist, childbirth educator, birth counsellor, and doula. She has assisted hundreds of women or couples through childbirth as a doula since 1968. She is the author of many books and articles on birth for both parents and professionals.* KATHIE LINDSTROM *has been a childbirth educator, doula trainer, and doula for many years. She currently manages the Perinatal Program at Douglas College in Vancouver, BC.* JALANA GRANT *has been working with childbearing families as a doula since 1983. She has also worked as a childbirth educator and doula trainer. She currently facilitates the doula program at the South Community Birth Program in Vancouver, BC.*