



Midwives' and doulas' perspectives of the role of the doula in Australia: A qualitative study

Jeni Stevens, RN, BN (Hons) (Registered Nurse/Student Midwife)^a,
 Hannah Dahlen, RN, RM, BN (Hons), M(CommN), PhD, FACM
 (Associate Professor of Midwifery)^{b,*}, Kath Peters, RN, BN (Hons), PhD (Senior Lecturer)^b,
 Debra Jackson, RN, PhD (Professor of Nursing)^b

^a Antenatal Clinic, Blacktown Hospital, PO Box 6105, Blacktown, NSW 2148, Australia

^b Family and Community Health Research Group, University of Western Sydney, Locked Bag 1797, Penrith South DC, NSW 1797, Australia

ARTICLE INFO

Article history:

Received 18 December 2009

Received in revised form

9 April 2010

Accepted 11 April 2010

Keywords:

Doula

Midwife

Midwifery

Continuity of care

Normal birth

ABSTRACT

Objective: to explore midwives' and doulas' perspectives of the role of the doula in Australia.

Background: doulas are relatively new in Australia; nevertheless, demand for them is increasing. Research has not previously explored the role of a doula in Australia. This research aimed to answer the question: What are midwives' and doulas' perspectives of the role of a doula in Australia?

Design: qualitative study using focus groups that were digitally recorded, transcribed and the data analysed using thematic analysis.

Setting: New South Wales, Australia.

Participants: 11 midwives and six doulas.

Findings: the key theme that emerged was that 'the broken maternity system' is failing women and midwives. The system is preventing midwives from providing woman-centred care. As a result, doulas are 'filling the gap' and midwives feel that doulas are 'taking our role'. Doulas fill the gap by providing continuity of care, advocating for women, protecting normal birth and by providing breast-feeding advice and emotional support in the community. Midwives are concerned that doulas are taking the caring part of their role from them and want the 'broken' maternity system fixed. Midwives described that doulas take their role from them by changing the relationship between themselves and labouring women, by reducing their role to obstetric nurses, by overstepping the doula role boundaries, and by holding the power at births.

Implications for practice: despite the conflict reported between midwives and doulas, both groups identified that they see the potential for future collaboration. Taking into account the continued employment of doulas, it is important to improve collaboration between midwives and doulas for the sake of childbearing women.

© 2010 Elsevier Ltd. All rights reserved.

Introduction

'Doula' is a Greek derived term for a woman helper who is experienced in providing continuous non-medical physical and emotional support before, during and after birth (Stein et al., 2004; Dundek, 2006; Campbell et al., 2007). The role of the doula is described as focusing on the mother's comfort and wishes during labour (Papagni and Buckner, 2006), and providing one-to-one continuous support through encouragement, non-medical information and comfort (Hottenstein, 2005). Doulas are unique in that they are employed by women yet have no decision-making responsibilities. They only have one labouring woman that they

devote themselves to and they remain with her throughout the whole labour and birth (Stein et al., 2004).

Doulas provide tailored support specific to each woman's needs by educating and encouraging them to write an informed birth plan, with the aim to facilitate normal births (Simkin and Way, 1998; Koumouitzes-Douvia and Carr, 2006). The World Health Organization (WHO) defines a normal birth as: a spontaneous birth that is low risk throughout the labour and birth; with the infant being born in the vertex position between 37 and 42 weeks of pregnancy; and mother and infant being in a good condition (Ahmed et al., 1997). The Lamaze Institute for Normal Birth adapted from WHO describes six evidence-based practices that promote normal birth. These practices are: labour begins on its own; the labouring mother has continuous labour support; there are no routine interventions; there will be spontaneous pushing in a gravity-neutral or upright position;

* Corresponding author.

E-mail address: jenistevens@bigpond.com (J. Stevens).

and there be no separation of mother and infant after birth to encourage bonding and breast feeding (Lamaze International, 2007).

The benefits of doula care include the provision of continuous labour support, reducing women's stress, provision of multi-cultural and religious support, support for women's partners, reduced interventions during birth and increased breast-feeding initiation (Campbell et al., 2006; Dundek, 2006; Hodnett et al., 2007). Doula support can decrease women's anxiety and the perception of pain, and thereby increase their ability to cope during labour (Murray and McKinney, 2006). A woman can employ a doula who has the same language, cultural and/or religious background, which may provide her with more appropriate and culturally sensitive care. Doulas are not only helpful to the mother but also support partners by acting as role models and by allowing the partner to take breaks (Ballen and Fulcher, 2006; Koumoutzes-Douvia and Carr, 2006). They can also increase breast-feeding initiation and provide continuing breast-feeding support (Langer et al., 1998; Scott et al., 1999; Hodnett et al., 2007; Nommsen-Rivers et al., 2009).

Doulas are relatively new in Australia; nevertheless, demand for them is increasing (Cencigalbulario, 2008). The rise in the use of doulas is thought to be due to increasing dissatisfaction with the current maternity health-care system. Women are generally not provided the continuity of care and emotional support they want within the maternity system; therefore, there are reports that doulas are taking over this care and doing what midwives traditionally used to do or indeed should do (Cencigalbulario, 2008). However, the doula role in Australia is unclear and almost no research has been undertaken into doulas in this country.

There are no standards for doula training in Australia, and they are not obliged to register with any regulating body (Bogossian, 2007). This lack of regulation is a major source of conflict between doulas and health professionals because anyone can be a doula regardless of how much training they have had. Conflict has been reported when midwives do not know how to intervene when they believe the doula is acting inappropriately (Gilliland, 2002). Some midwives say that conflict occurs when doulas work outside their scope of practice and give medical advice (Ballen and Fulcher, 2006). Furthermore, conflict may be present due to midwives feeling uncomfortable because doulas are providing the care they want to provide (Gilliland, 2002). Even though research shows that a midwife can rely on the doula to provide the emotional support for the woman, handing over this support can be difficult because caring is the core of the midwives' role, and many midwives feel territorial about their role (Hottenstein, 2005; Ballen and Fulcher, 2006; Bianchi, 2006; Buck and Bianchi, 2006). Midwives in Australia are increasingly reporting concern and tension between themselves and the emerging role of the doula.

This research aimed to answer the question: What are midwives' and doulas' perspectives of the role of a doula in Australia? Specific purposes and objectives were to: identify midwives' perceptions of the role of a doula; identify how doulas see their role; provide insight into what contributes to these perceptions; identify the implications of these perceptions; and increase midwives' understanding of the role of a doula.

Method

A qualitative method was determined to be appropriate for this research because it is a technique used to collect and analyse data in areas where there is little knowledge, and it seeks to answer 'what' questions (Green and Thorogood, 2005; Grbich, 2007; Schneider et al., 2007). Focus groups were chosen as a

suitable form of data collection in this research because they have been shown to enhance participant retention rates and provide a means of obtaining large amounts of verbal information, because participants trigger additional information from each other (Marshall and Rossman, 1999; Wood and Ross-Kerr, 2006; Schneider et al., 2007). A convenience sample of five or six participants for each focus group was chosen because previous research has shown that a small group of participants can provide abundant amounts of information-rich data (Borbasi et al., 2004).

Due to varied working environments for midwives, three focus groups were conducted in total (two for midwives, one for doulas). Hospital and privately practising midwives were included to obtain a broader range of perspectives. Of the midwife focus groups, one had six participants and the other had five participants (midwives $n=11$). The doula focus group had six participants in total. There are still not many doulas in Australia (exact numbers are unknown) and they are spread widely. Although only one focus group was conducted with doulas, the data obtained were rich and there was excellent consensus in the group.

Following ethical clearance, midwives and doulas were initially contacted by email or telephone though personal contacts or through website searches. Snowball sampling was used to allow the potential participants to recruit further potential participants; therefore, the initial contacts were then asked if they knew any other potential participants (Qualitative Research Working Group, 1995; Borbasi et al., 2004). The participants were recruited from the Sydney area and the Blue Mountains because of the increasing numbers of doulas who have been providing care for mothers in these areas.

To be eligible to participate in the research, both midwives and doulas were required to meet specific criteria. Midwives needed to have more than three years of experience, to be currently working as a midwife and to have worked with doulas. Doulas needed to have attended an initial doula education course lasting three or more months, and needed to be currently practising as a doula. This criterion ensured that participants were experienced in their field. Midwives and doulas were excluded if they were currently or had previously worked in the opposite role (e.g. midwife was previously a doula), because it was perceived that their insight into the opposite role could affect the results of the research (Endacott and Botti, 2005).

The three focus groups were facilitated by two researchers. The researchers ensured that the important issues were covered with the use of a question sheet. The questions that were asked of midwives and doulas were:

1. What is the role of a doula in pregnancy, birth and the postnatal period?
2. What has been your experience working as, or interacting with, doulas in the care of women?
3. How do you think the presence of a doula affects the experience of a woman?
4. What do you think are the limits of the role of a doula?
5. What interactions stand out whilst you worked with/as a doula?

Credibility in research is achieved by providing clear conclusions that reflect the complexity of the participants' reality, whilst making sure that the researchers' preconceptions do not influence the conclusions (Sigsworth, 1995). The first author completed this research for a nursing honours degree. She is neither a midwife nor a doula, and had no prior knowledge of what a doula was. The other authors are all nurses, and one is also a midwife. None of the researchers are doulas.

Thematic analysis was selected because it unearths patterns in the data, allowing for the discovery of the true meaning of the data (Boyatzis, 1998; Grbich, 2007). This involved repeated listening to the digital recordings of the focus groups, and reading the transcripts to become familiar with the data collected; comparing and contrasting this data; identifying, analysing and reporting common themes within the data; coding and naming these themes; and reporting the results of this analysis (Boyatzis, 1998; Green and Thorogood, 2005; Braun and Clarke, 2006). To help reduce the potential for bias, all four team members individually undertook a thematic analysis, and then met together to compare results, resolve any points of divergence in interpretation of the data, and reach consensus with the themes. On completion of this process, the team reached agreement and all concurred that the resultant well-defined themes accurately represented the data collected. This process was crucial to establishing dependability of the themes (Boyatzis, 1998).

Findings

There were 11 midwives and six doulas involved in the research. The midwives were all female and aged over 31 years; the majority were between 41 and 50 years of age. The midwives had between three and 30+ years of experience; the majority had between 11 and 20 years of experience. The midwives worked in postnatal wards, antenatal wards, childbirth suites, birthing units, midwife clinics, midwifery at home and private practice, and one worked as a clinical midwifery consultant. The midwives had worked with doulas between one and 20 times; the majority had worked with doulas between 10 and 20 times. Midwives had been at a birth between one and 30 times within the previous year; the majority had been at a birth between 10 and 20 times within the previous year.

The doulas were all female and aged between 24 and 40 years; the majority were over 31 years old. They had between one and 10 years of experience; the majority had between three and four years of experience. The majority supported women to give birth in childbirth suites followed by birth centres. Half had attended home births during their careers. They had assisted at between one and 21+ births during the previous year; the majority had assisted at between one and five births during the previous year.

The key theme recognised was how 'the broken maternity system' is failing women and midwives. As a result, doulas perceive they are 'filling the gap' and midwives feel that doulas are 'taking our role'. Doulas are filling the gap by providing continuity of care, advocacy, protecting normal birth and by being part of the community, thus being accessible and constant. Midwives perceive that doulas are taking their role by changing the relationship between the woman and midwife, by overstepping the boundaries, reducing midwives to being obstetric nurses and through holding the power. Despite the conflict that had resulted from doulas being employed, both doulas and midwives saw the potential for collaboration (Fig. 1).

The Broken Maternity System

The key theme in this study was how 'the broken maternity system' is failing women and midwives. As a result, doulas perceive that they are 'filling the gap' and midwives described doulas as 'taking our role'.

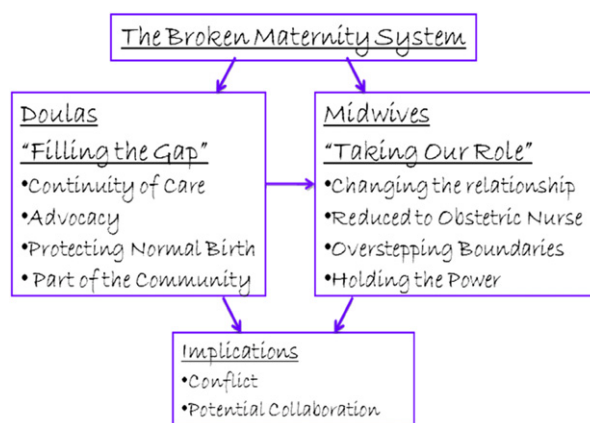


Fig. 1. Themes and subthemes.

The broken maternity system

Both doulas and midwives believed that the current maternity system in Australia is failing women. Areas that were highlighted by midwives were that they could not provide woman-focused care because the system is fragmented, overloaded and medically dominated. Hospital-based midwives stated that doulas are being employed by women because midwives do not have the opportunity to provide continuity of care, they find it difficult to advocate for women due to feeling powerless because they are aligned to the maternity system, and do not have the time to support women properly. Doulas noted that: the current systems do not support the woman and her choices; everything is run by a clock; midwives are bound by the system; and insufficient breastfeeding education is available to women. Both midwives and doulas commented that the system would be improved if midwives could provide continuity of midwifery care:

I mean it makes me think about staffing levels and how much we can be with women and all of that. It is not that many years ago that pretty much every labouring woman just had a midwife with her and there was maybe less of a need then for doulas and now I guess if midwives are, I don't know, answering buzzers on postnatal wards and running in and out of birthing rooms, it makes me think of that all the time, that I would love to just be able to be with this woman in labour. It is only may be 10 years ago that we were just able to do that (Midwife).

...midwifery has gone into this really clinical kind of role where they spend more time doing paperwork or whatever they do when they're not in the room with you, and not being with women as their role suggests (Doula).

Filling the gap

Doulas reported providing a continuity of care that women generally do not have access to in the current broken maternity system. This care is focused on the woman's needs and is not time dependent:

It's the continuity too. They know that you're not going to leave them. It's the presence. When you're actually with them, you're totally present. There is nowhere else you need to be. You know, you've organised your family by that point. There is nothing else I should have to do other than be in that room (Doula).

Doula described being contactable 24 hours a day and supporting women for as long as they wanted, even into future pregnancies. They described their role as filling the gap in the maternity system by being advocates for women, by asking

questions of the health-care team, and by encouraging partners to speak up for women.

For many women, going to hospital is just like going to a foreign country where they don't speak the language. A doula is just like having a phrase book. It's just having someone with you who can interpret the language, interpret the scenario, help you get through it (Doula).

Doulas educate women and encourage them to make birth plans, therefore giving women the power of choice in their birth. They also fill the gap in the maternity system by protecting normal birth. To do this, they keep women home for longer periods of time to avoid unnecessary interventions, and reassure partners that everything is proceeding normally during birth:

I actually think that in the hospital system as it is now, one of the biggest roles of the doula is actually to buy time. They can't start the clock until you walk through the door (Doula).

Some doulas subverted the system both covertly and overtly in order to support a woman to achieve a normal birth:

In the end, she did have the Synto [Syntocinon to augment the labour], after we had actually managed to lock the doctor out of the room for 45 minutes (Doula).

Doulas also fill the gap by being a part of the community. They attend local community meetings, which not only helps with their own education but also raises awareness about the service they provide in the community, such as postnatal support and breast-feeding advice:

I get a lot of women call me that I have never met before. They call me and say someone in the community told me about you, I can't get into the child health nurse for six weeks, is there something you can do for breast feeding, or just to debrief about the birth or whatever (Doula).

Doulas perceived that all these issues need to be addressed whilst providing care for childbearing women. These needs are not adequately attended to in the current system by midwives, so doulas fill the gap:

I think that there is a whole section of midwifery that has been lost, and the doulas are now filling that gap (Doula).

The midwives and doulas in this study believed that the current maternity system in Australia is broken. Midwives are too busy to provide woman-centred care because of decreased staffing levels and the lack of continuity of care models. Doulas felt that the majority of birthing women do not have power or choice in the current hospital system.

Taking our role

During the midwives' focus groups, it became evident that midwives feel that doulas are taking their role from them; however, midwives attribute this to the system, as it does not facilitate them to fulfil their role:

I think what we should be looking for is continuity of midwifery care, not how can we fill the gap with a doula (Midwife).

The midwives in the focus groups were concerned that due to the broken maternity system, they could not provide woman-centred care. They believed that both the maternity system and doulas are altering their role, with doulas taking on the midwives' role and changing the relationship between them and the woman:

I find they already have people that they have bonded with and things like that so I don't get that bonding kind of thing because I'm not in there enough (Midwife).

Midwives stated that they feel disadvantaged because they often cannot provide continuity of care and they do not get the same opportunities to build up a relationship with women. Having a doula was described as changing the dynamics of the woman/midwife relationship, leaving midwives feeling, at times, like intruders at the birth:

It acts like a buffer around the woman that actually increases the distance between the midwife and the woman and I think that is part of the appeal to people ... If they don't trust the hospital system they want somebody who is going to stand in that buffering role (Midwife).

Sometimes midwives felt that doulas manipulated women into not trusting them, with the purpose of protecting the woman from the system:

The negative is when you walk into a room and you feel that you are intruding and that you should not be walking in there and people are suspicious of you and you are unable to get to the woman to be able to develop some kind of trust or relationship ... I find it really difficult to function around them and I find it really difficult to talk to women who have been told set things (Midwife).

The midwives described feeling that doulas are taking over the caring part of their role, reducing their role to that of an obstetric nurse:

I feel like they are doing my job and I feel delegated to the obstetric nurse who is the meanie who just comes in and does the VEs [vaginal examinations] and blood pressures and everything else because you don't need 10 people rubbing your back (Midwife).

In addition, the midwives believed that doulas overstepped their boundaries by providing education that was, at times, misinformed and inappropriate, and also by providing clinical care and advice:

I see that as overstepping boundaries. Because that is a medical area if she has needed a caesarean for something and doulas are not trained in that and I would think that a doula would not have the necessary experience to say I [sic] should have refused a caesar (Midwife).

This, in turn, made the midwives feel vulnerable as they are accountable and legally responsible for the well-being of women and their babies. The midwives in this study described several cases where doulas overstepped their role and, they believed, encouraged women to stay at home until late in the labour or even to give birth at home with no professional in attendance. Midwives also described how vulnerable this made them feel:

It makes me feel really vulnerable because I am the one who is going to be held to account if there is any problem with that baby, particularly in our work environment (Midwife).

The midwives believed that doulas hold the power in births they attend because they are not responsible for birthing outcomes, they can have an impact on women's birthing decisions, and they can manipulate situations. Midwives commented that doulas have power because they are an active part of the community. Doulas can influence women's birthing choices by making comments about hospitals, midwives and through the development of birth plans. One midwife was

disappointed to discover that a doula had been commenting to women that ‘they are just not providing good care’ at her hospital. The midwives conveyed the difficulty in doing their job when doulas have already discussed a birth plan with women:

I go through the plan with them and then kind of go we don’t do this, we don’t do that and I always think that is a successful conversation if the woman then says to you ‘oh you are telling me I don’t need this birth plan?’ ‘Yes that is right’ and I think yes, you know (Midwife).

The midwives in this study were concerned that, due to the broken maternity system, they could not provide woman-centred care and doulas were able to do this and were taking their role. They believed that both the maternity system and doulas are altering their role. The perception that doulas were providing a level of support to women that midwives were unable to match led to conflict.

Conflict and potential collaboration

The main implication of doulas ‘filling the gap’ and ‘taking our [midwives’] role’ is conflict; however, it was clear in this study that there was also the potential for collaboration. There is no doubt that when doulas become part of the woman’s birth support, the result is often conflict with mainstream maternity service providers. Nevertheless, both midwives and doulas stated that they cannot understand why there is so much conflict, and that they should be able to work together because they both want the same outcome.

Midwives commented that they sometimes feel undermined when a woman employs a doula. On occasion, midwives felt that doulas attended births to be obstructive. Midwives also felt annoyed when doulas overstepped their role and encroached on what they saw as the midwives’ role:

Originally I thought doulas were fantastic and I thought oh this is great. I had not heard of them until I worked at [public hospital] but I have had a couple of good experiences but more really negative experiences and now I can’t stand them (Midwife).

Doulas noted that they often felt upset by the way they were treated at births, and reported that sometimes midwives mistreat or ignore them:

She [midwife] looked at me and pretty much told me to shut up and said that she couldn’t listen to anything that I said ... it was just – they hated me (Doula).

Despite the conflict, both the midwives and doulas in the focus groups saw the potential for collaboration. Midwives occasionally praised the care that doulas provide:

I work with such a range of doulas. There’s some really great doulas out there. They do the back rubbing and the pool filling and they step back and let hubby do it, and afterwards they come and help with baby settling techniques and all that kind of stuff (Midwife).

Doulas, in turn, revealed that they are advocates for midwives and feel disappointed for midwives that they cannot provide the woman-centred care they want to:

We feel for midwives quite a bit actually. Here we are, the home birthers, the primary people showing up at these rallies. We do support the midwives. We understand that they are bound by a system. We’re totally in support of them (Doula).

Doulas elaborated stating that they are really happy with the new Australian Government maternity service reforms to be

implemented in 2010, giving midwives access to funding, prescribing rights and insurance, as this would allow midwives to provide continuity of care for women, expand woman’s birth choices and potentially reduce interventions:

I think the new budget thing is going to mean that women who are low-risk and don’t need obstetric involvement can get through their pregnancy without obstetric involvement. For any doula, that is fantastic news because that is going to reduce risk of intervention (Doula).

Both doulas and midwives acknowledged that they strive for the same outcome – the best for the woman and her infant. To help facilitate a harmonious professional working relationship, both midwives and doulas stated that they were eager to meet with each other, with the aim of potentially reducing the conflict between them:

Out in a community where there’s a high number of doulas working and often at the hospital, you know, there potentially might be some benefit of having some sort of interaction between the staff (Midwife).

Midwives commented that conflict would be reduced further with the regulation of doulas:

I’m very much in favour of regulating doulas. You have to do a course to do it, but the course is set to a certain standard like a university course would be. There’s a pass mark, but then you have to be registered and then only those people can practice as doulas (Midwife).

Discussion

During the study, it became evident that both the participating midwives and doulas believed that the current Australian maternity health-care system is failing women, and that doulas are being employed by women because the broken maternity system does not adequately meet their needs. Previous research also suggests that a large percentage of Australian childbearing women feel that they are given little or no choice in birth (Gamble et al., 2007). Women who birth in hospital feel that they are processed, and are not given the time they need to discuss issues of importance (Finlay and Sandall, 2009). They report that health professionals in the maternity system are not always sensitive to their needs, that midwives are too busy, that they do not always give helpful advice, and that they are sent home too early after the infant is born (Brown et al., 2005). However, women reflect positively about their care when they do happen to experience continuity of midwifery care (Rowley et al., 1995; Brodie, 2002; Brown et al., 2005; Hatem et al., 2008; Homer et al., 2008).

Doulas in the current study stated that women choose to employ doulas because women do not have birthing choices in the current health system. Australian maternity care is dominated by a medicalised system that restricts women’s choices (Brodie, 2002). It is expected by health professionals that the patient will submit to the health expert (Pairman et al., 2006). Additionally, the current maternity system does not support normal physiological birth (Keating and Fleming, 2009).

Doulas in this study reported that women were often not given appropriate support and education, particularly with regards to common childbirth interventions. They saw their role as often compensating for this deficit in the maternity system, which also led them to overstep their role boundaries according to the midwives. Research indicates that women feel frustrated that they are either not informed or only communicated the bare amount of information about medical interventions

(Maher, 2008). As doulas commented in this study, women are unable to fully participate in birthing decisions if they are not supported with appropriate education. Women want to be informed so they can participate in decision-making during labour (Gamble et al., 2007), and being informed is significant to how women evaluate their birth experiences (Dahlen et al., 2010).

A recent systematic review concluded that 'all women should be allowed and encouraged to have support people with them continuously during labour' (Hodnett et al., 2007, p. 10). There is no doubt that continuity of care has many benefits for the woman and her infant, such as reduced analgesia/anaesthesia, less instrumental and caesarean section births, and decreased negative birth experiences (Campbell et al., 2006; Hodnett et al., 2007; Hatem et al., 2008; McGrath and Kennell, 2008; Nommsen-Rivers et al., 2009). Despite this, continuity of care is generally not accessible in mainstream Australian maternity systems (Reid et al., 2007), with only 3–5% of women able to access continuity of care with midwives (Homer et al., 2008; Dahlen, 2009). Although around 30% of Australian women can get continuity of care in pregnancy and birth with an obstetrician, they will be cared for by midwives not known to them in labour and during the postnatal period (Laws and Hilder, 2008).

Continuity of midwifery care has been shown to work on a large scale, and is therefore a feasible model for Australia. For the past two decades, New Zealand has provided women-centred midwifery care where most women are able to choose who will be their primary carer for their birth (Pairman et al., 2006; New Zealand College of Midwives, 2009). Over 78% of New Zealand women choose to have a midwife as their primary carer, which entitles them to have publicly funded care from the midwife from early pregnancy to six weeks post partum (New Zealand College of Midwives, 2009). Women who have this level of care do not need to birth in a hospital, and are encouraged to birth wherever they feel comfortable (New Zealand College of Midwives, 2009).

Whilst this may seem ideal, there are some barriers to implementing this care in Australia. Midwives in Australia do not have experience in all areas of midwifery care, and therefore do not feel that they are currently able to provide this care (Brodie, 2002). Additionally, maternity care will have to change from being medically dominant to woman centred (Homer et al., 2009). Furthermore, the shortage of qualified midwives in Australia will need to be addressed (Brodie, 2002).

Continuity of care was seen by doulas as a core part of their role. It was apparent in this study that doulas provide continuity of care in Australia because women do not get the benefits of this care within the fragmented maternity care system. Doulas stated that they aim to get to know the woman and her family, so they can be provided with the best care possible. They also reported that the continuity of care they provided had no time limits. Midwives in the study said that they could not provide care without time limits due to lack of staffing and the limited availability of continuity of care models.

Doulas may be better advocates than midwives in the current maternity care system because they are only accountable to the woman, whereas midwives are also legally accountable to the medicalised system, and are often not given time and the opportunity to provide continuity of care (Rosen, 2004; Stein et al., 2004; International Confederation of Midwives, 2005; Kitzinger, 2008; Finlay and Sandall, 2009). Midwives have stated that they occasionally have to fight the system to be the woman's advocate (Finlay and Sandall, 2009). Women in Australia and midwives alike share the need for midwives to provide continuity of care (Homer et al., 2009). Midwives feel trapped in the system they are required to comply with, and feel confronted when they give away their caring role to doulas (Buck and Bianchi, 2006; Kitzinger, 2008).

Midwives in this study believed that doulas act as a barrier between the woman and the hospital system. Some midwives feel that, occasionally, doulas manipulate the woman into thinking that midwives cannot be trusted. Midwives also stated that they get frustrated when doulas overstep their role when they give women medical advice, because they are not adequately qualified to advise women about potential interventions. This resonates with previous research which found that midwives believe doulas work outside their scope of practice when they give medical advice (Ballen and Fulcher, 2006; Green and Hotelling, 2009). Gilliland (2002) noted that doulas should not give advice or share their opinion on medical issues as they overstep their boundaries if they are not qualified.

Despite the conflict, the findings of this research revealed the potential for collaboration between midwives and doulas. Midwives and doulas both commented that they could not understand why there is conflict, because '... we are all trying to get the same outcome...'. Midwives also stated that they appreciate doulas' help at times and believe that they provide great care. Ballen and Fulcher (2006) supported these findings by stating that some midwives recognised that doulas were helpful in meeting women's needs. They also stated that doulas also appreciate feedback and direction from midwives (Ballen and Fulcher, 2006). Doulas in this research noted that 'we are great advocates of midwives'. They mentioned that they feel for midwives because they know that midwives want to provide holistic care, but recognise that they cannot in the current maternity system. This mutual recognition provides hope that both doulas and midwives can work collaboratively for the benefit of childbearing women.

Implications for practice

As there is a need for doulas in Australia at the present time due to an inadequate maternity care system, and given that there may always be a demand for doulas, breaking down barriers between midwives and doulas is essential. In this research, both doulas and midwives identified that communicating with each other would be a good step towards improving collaboration. Some participants in the current study suggested that regular formal or informal meetings would enhance relationships between midwives and doulas. Doulas recognised that midwives do not fully understand the doula role, and said that meeting with each other could improve their understanding.

Additionally, midwives in this study concur with observations made previously suggesting that doulas should be regulated and the role defined in order to better serve women and to potentially reduce conflict between midwives and doulas (Bogossian, 2007). However, regulating doulas may have a negative effect on the relationship between doulas and the women they look after. Doulas can, at times, be greater advocates for women because they are only accountable to women and not a health service or regulation authorities (Hodnett et al., 2007). However, regulation may be necessary to safeguard women from people who claim to be doulas even though they have had no training (Bogossian, 2007), or from doulas that step outside their role.

Future research

This study provides some insights into the role of a doula in Australia. The participants in the study all came from the same geographic area in New South Wales; therefore, the findings may not be replicated in other settings and areas. Furthermore, only midwives who have worked with doulas were interviewed, so the midwives' views in the research may not be congruent with the views of other midwives and health professionals. Further

research is needed to fully understand the role of a doula in Australia. It would be important to involve midwives and doulas from other geographical areas, particularly rural and remote areas where women's choices may be more limited. It would also be valuable to obtain the views of childbearing women who choose to be supported by a doula. Further research could also focus on the use of doulas in culturally specific contexts. Doula care for Indigenous women should be studied and considered for potential benefits. These views would provide a more comprehensive insight into the role of a doula.

Conclusion

This research is the first research undertaken that aims to understand the role of a doula in Australia. Doulas are employed by women to primarily 'fill the gap' in, 'the broken maternity system' in Australia. When doulas provide continuity of care, midwives feel that doulas are 'taking our role' because they are meant to be 'with women'. Despite the conflict, both midwives and doulas see the potential for collaboration. The benefits of continuity of care are strongly supported by research, and it is anticipated that this option will be more available to women with the Australian Government's maternity service reforms. This could improve the childbirth outcomes for both women and their infants, and would potentially improve midwives' satisfaction with work because they would be able to provide the care they want to provide. However, despite these reforms, doulas will continue to be hired by women in Australia; therefore, it is important to improve collaboration between midwives and doulas. Facilitating ways in which doulas and midwives can meet regularly could be beneficial in improving collaboration. The potential for regulating doulas needs to be examined further.

Acknowledgements

We would like to thank all the midwives and doulas that participated in this research. Without their willingness to give their time and to discuss their thoughts, this research would not have been accomplished.

References

- Ahmed, Y., Baveja, R., Foord, F., et al., 1997. Care in Normal Birth: a Practical Guide. World Health Organization (WHO) Department of Reproductive Health and Research. <http://www.who.int/reproductive-health/publications/MSM_96_24/care_in_normal_birth_practical_guide.pdf>.
- Ballen, L.E., Fulcher, A.J., 2006. Nurses and doulas: complementary roles to provide optimal maternity care. *Journal of Obstetric, Gynecologic, & Neonatal Nursing* 35, 304–311.
- Bianchi, A., 2006. Reply from Ann Bianchi. *Association of Women's Health, Obstetric and Neonatal Nurses: Lifelines* 10, 279–280.
- Bogossian, F., 2007. The Winston Churchill Memorial Trust of Australia. <http://churchilltrust.encode.net.au/res/File/Fellow_Reports/Bogossian%20Fiona.pdf>.
- Borbasi, S., Jackson, D., Langford, R.W., 2004. Navigating the Maze of Nursing Research: an Interactive Learning Adventure. Mosby Elsevier, Marrickville.
- Boyatzis, R.E., 1998. Transforming Qualitative Information: Thematic Analysis and Code Development. Sage Publications, California.
- Braun, V., Clarke, V., 2006. Using thematic analysis in psychology. *Qualitative Research in Psychology* 3, 77–101.
- Brodie, P., 2002. Addressing the barriers to midwifery – Australian midwives speaking out. *Australian Journal of Midwifery* 15, 5–14.
- Brown, S.J., Davey, M.-A., Bruinsma, F.J., 2005. Women's views and experiences of postnatal hospital care in the Victorian survey of recent mothers 2000. *Midwifery* 21, 109–126.
- Buck, L., Bianchi, A., 2006. On labor support and doulas. *Association of Women's Health, Obstetric and Neonatal Nurses: Lifelines*, 10, 279–280.
- Campbell, D., Scott, K.D., Klaus, M.H., Falk, M., 2007. Female relatives or friends trained as labor doulas: outcomes at 6 to 8 weeks postpartum. *Birth* 34, 220–227.
- Campbell, D.A., Lake, M.F., Falk, M., Backstrand, J.R., 2006. A randomized control trial of continuous support in labor by a lay doula. *Journal of Obstetric, Gynecologic, & Neonatal Nursing* 35, 456–464.
- Cencigalbulario, L., 2008. Doulas make an ideal choice – mums, bubs and toddlers: a special advertising report. *The Daily Telegraph*, p. 48. <<http://proquest.umi.com/pqdweb?did=1581960521&Fmt=7&clientId=8429&RQT=309&VName=PQD>> (last accessed 21/03/2009).
- Dahlen, H., 2009. Lessons from labour. <<http://www.abc.net.au/unleashed/stories/s2543589.htm>>.
- Dahlen, H.G., Barclay, L.M., Homer, C.S.E., 2010. The novice birthing: theorising first-time mothers' experiences of birth at home and in hospital in Australia. *Midwifery*, in press 26, 53–63.
- Dundek, L.H., 2006. Establishment of a Somali doula program at a large metropolitan hospital. *Journal of Perinatal & Neonatal Nursing* 20, 128–137.
- Endacott, R., Botti, M., 2005. Clinical research 3: sample selection. *Intensive and Critical Care Nursing* 21, 51–55.
- Finlay, S., Sandall, J., 2009. "Someone's rooting for you": continuity, advocacy and street-level bureaucracy in UK maternal healthcare. *Social Science & Medicine* 69, 1–8.
- Gamble, J., Creedy, D.K., Teakle, B., 2007. Women's expectations of maternity services: a community-based survey. *Women and Birth* 20, 115–120.
- Gilliland, A.L., 2002. Beyond holding hands: the modern role of the professional doula. *Journal of Obstetric, Gynecologic, & Neonatal Nursing* 31, 762–769.
- Grbich, C., 2007. *Qualitative Data Analysis: an Introduction*. Sage Publications Ltd., London.
- Green, J., & Hotelling, B.A. (2009). Healthy birth practices #3: bring a loved one, friend, or doula for continuous support. Retrieved from <<http://www.lamaze.org/ChildbirthEducators/ResourcesforEducators/CarePracticePapers/ContinuousSupport/tabid/486/Default.aspx>>.
- Green, J., Thorogood, N., 2005. *Qualitative Methods for Health Research*. Sage Publications Ltd., London.
- Hatem, M., Sandall, J., Devane, D., Soltani, H., Gates, S., 2008. Midwife-led versus other models of care for childbearing women. *The Cochrane Collaboration*, 1–130. <<http://www.mrw.interscience.wiley.com/cochrane/cclsyrev/articles/CD004667/frame.html>>.
- Hodnett, E., Gates, S., Hofmeyr, G., Sakala, C., 2007. Continuous support for women during childbirth. *Cochrane Database of Systematic Reviews* CD003766.
- Homer, C., Brodie, P., Leap, N., 2008. *Midwifery Continuity of Care: a Practical Guide*. Elsevier Australia, Chatswood.
- Homer, C.S.E., Passant, L., Brodie, P.M., et al., 2009. The role of the midwife in Australia: views of women and midwives. *Midwifery*, in press 25, 673–681.
- Hottenstein, S.E., 2005. Continuous labor support. Creating optimal birth experiences through theory-driven nursing care. *Association of Women's Health, Obstetric and Neonatal Nurses: Lifelines* 9, 242–247.
- International Confederation of Midwives, 2005. Definition of the Midwife. <<http://www.internationalmidwives.org/Portals/5/Documentation/ICM%20Definition%20of%20the%20Midwife%202005.pdf>>.
- Keating, A., Fleming, V.E.M., 2009. Midwives' experiences of facilitating normal birth in an obstetric-led unit: a feminist perspective. *Midwifery* 25, 518–527.
- Kitzinger, S., 2008. Letter from Europe: home birth, midwives, and doulas. *Birth* 35, 250–252.
- Koumouitzes-Douvia, J., Carr, C.A., 2006. Women's perceptions of their doula support. *Journal of Perinatal Education* 15, 34–40.
- Lamaze International, 2007. The Six Care Practices that Support Normal Birth <<http://www.lamaze.org/Default.aspx?tabid=90>> (last accessed 26/05/2008).
- Langer, A., Campero, L., Garcia, C., Reynoso, S., 1998. Effects of psychosocial support during labour and childbirth on breastfeeding, medical interventions, and mothers' wellbeing in a Mexican public hospital: a randomised clinical trial. *BJOG: an International Journal of Obstetrics and Gynaecology* 105, 1056–1063.
- Laws, P., Hilder, L., 2008. Australia's Mothers and Babies 2006. *Perinatal Statistics Series No. 22*. Cat No. PER 46. <[http://www.npsu.unsw.edu.au/NPSUweb.nsf/resources/AMB_2008/\\$file/ps22.pdf](http://www.npsu.unsw.edu.au/NPSUweb.nsf/resources/AMB_2008/$file/ps22.pdf)>.
- Maher, J., 2008. Progressing through labour and delivery: birth time and women's experiences. *Women's Studies International Forum* 31, 129–137.
- Marshall, C., Rossman, G.B., 1999. *Designing Qualitative Research*. 3rd edn. Sage Publications Ltd., California.
- McGrath, S.K., Kennell, J.H., 2008. A randomized controlled trial of continuous labor support for middle-class couples: effect on cesarean delivery rates. *Obstetrical and Gynecological Survey* 63, 620–621.
- Murray, S.S., McKinney, E.S., 2006. *Foundations of Maternal New-Born Nursing*. 4th edn. Saunders, St. Louis.
- New Zealand College of Midwives, 2009. *Maternity Services in New Zealand*. <<http://www.midwife.org.nz/index.cfm/1,87,html>>.
- Nommensen-Rivers, L.A., Mastergeorge, A.M., Hansen, R.L., Cullum, A.S., Dewey, K., 2009. Doula care, early breastfeeding outcomes, and breastfeeding status at 6 weeks postpartum among low-income primiparous. *Journal of Obstetric, Gynecologic, & Neonatal Nursing* 38, 157–173.
- Pairman, S., Pincombe, J., Thorogood, C., Tracy, S., 2006. *Midwifery: Preparation for Practice*. Elsevier Australia, Marrickville.
- Papagni, K., Buckner, E., 2006. Doula support and attitudes of intrapartum nurses: a qualitative study from the patient's perspective. *Journal of Perinatal Education* 15, 11–18.
- Qualitative Research Working Group, 1995. *Ethical Aspects of Qualitative Methods in Health Research: an Information Paper for Institutional Ethics Committees*. National Health and Medical Research Council, Canberra.
- Reid, J., O'Reilly, R., Beale, B., Gillies, D., Connell, T., 2007. Research priorities of NSW midwives. *Women and Birth* 20, 57–63.
- Rosen, P., 2004. Supporting women in labor: analysis of different types of caregivers. *Journal of Midwifery and Womens Health* 49, 24–31.

- Rowley, M., Hensley, M., Brinsmead, M., Wlodarczyk, J., 1995. Continuity of care by a midwife team versus routine care during pregnancy and birth: a randomised trial. *Medical Journal of Australia* 163, 289–293.
- Schneider, Z., Whitehead, D., Elliott, D., Lobiondo-Wood, G., Haber, J., 2007. *Nursing and Midwifery Research: Methods and Appraisal for Evidence-Based Practice*. 3rd edn. Elsevier Australia, Marrickville.
- Scott, K.D., Klaus, P.H., Klaus, M.H., 1999. The obstetrical and postpartum benefits of continuous supports during childbirth. *Journal of Women's Health and Gender-Based Medicine* 8, 1257–1264.
- Sigsworth, J., 1995. Feminist research: Its relevance to nursing. *Journal of Advanced Nursing*, 22(5), 896–899.
- Simkin, P., Way, K., 1998. Position Paper: the Doula's Contribution to Modern Maternity Care. Doulas of North America. <<http://www.dona.org/PDF/BDPositionPaper.pdf>>.
- Stein, M.T., Kennell, J.H., Fulcher, A., 2004. Benefits of a doula present at the birth of a child. *Journal of Developmental & Behavioral Pediatrics* 24, 195–198.
- Wood, M.J., Ross-Kerr, J.C., 2006. *Basic Steps in Planning Nursing Research: from Question to Proposal*. 6th edn. Jones and Bartlett Publishers, Sudbury.