The Life of a Canadian Doula: Successes, Confusion, and Conflict

Sahba Eftekhary, MD, MPH, MHA,[1] Michael C. Klein, MD, CCFP, FAAP, FCFP, ABFP,[2,3] Shi Yi Xu, BSc[3]

[1]Department of Health Policy, Management and Evaluation, University of Toronto, Toronto ON

[2]Departments of Family Practice and Paediatrics, University of British Columbia, Vancouver BC

[3]Developmental Neurosciences and Child Health Research Cluster, Child and Family Research Institute, Vancouver BC

Abstract

Objective: Despite evidence that doulas improve maternal and newborn outcomes, some maternity care professionals have had difficulty both in understanding the role of doulas and in accepting doulas as collaborators. We sought to examine the backgrounds, practices, and professional motivations of doulas and to understand their role and interactions with other maternity care providers.

Methods: We conducted a postal survey of 212 Canadian doulas whose contact information was provided by DONA International. The main outcome measures of the survey were demographics, practices, motivations, perception of working environment, interactions with and acceptance by other maternity care providers, and overall work satisfaction.

Results: The most common reasons for becoming a doula were the desire to support women in childbirth, personal interest, and a wish to share their own positive birth experience with others. Only 21.7% described the doula role as a means of achieving personal financial support. Most respondents intended to continue doula work in the next five years. Doulas felt more accepted by midwives than other care providers. Most doulas reported no conflict with other maternity care providers, but on rare occasions, doulas had been excluded from attending birth by maternity care providers, hospital and/or administrative regulations, and rarely by a client. Almost all doulas (98.5%) rated their overall professional experience as good or excellent.

Conclusion: Better recognition and respect from other providers significantly influenced doulas' satisfaction. This study helps clarify areas of possible conflict and obstacles that doulas may face in their work environment and in their interactions with other maternity care providers.

Key Words: Doula, childbirth support, maternity care services, Caesarean section, obstetrical interventions

Competing Interests: None declared.

Received on October 27, 2009

Accepted on January 13, 2010

Résumé

Objectif : Malgré l'existence de données indiquant que le recours aux services de doulas améliore les issues maternelles et néonatales, certains professionnels des soins de maternité ont eu de la difficulté à comprendre le rôle des doulas et à les accepter à titre de collaboratrices. Nous avons cherché à examiner les antécédents, pratiques et motivations professionnelles des doulas, ainsi qu'à comprendre leur rôle et leurs interactions avec les autres fournisseurs de soins de maternité.

Méthodes : Nous avons mené un sondage postal auprès de 212 doulas canadiennes dont les coordonnées nous ont été fournies par DONA International. Les principaux critères d'évaluation de ce sondage étaient leurs caractéristiques démographiques, leurs pratiques, leurs motivations, leur perception du milieu de travail, leurs interactions avec les autres fournisseurs de soins de maternité et la mesure dans laquelle elles se sentent acceptées par ceux-ci, et leur satisfaction globale au niveau professionnel.

Résultats : Les raisons les plus courantes de devenir une doula étaient le souhait de soutenir les femmes pendant l'accouchement, les intérêts personnels et le souhait de partager sa propre expérience positive d'accouchement avec d'autres. Seules 21,7 % des répondantes ont décrit le rôle de doula comme étant un moyen de subvenir à ses besoins sur le plan financier. La plupart des répondantes prévoyait continuer de travailler à titre de doula au cours des cinq prochaines années. Les doulas se sentaient plus acceptées par les sages-femmes que par les autres fournisseurs de soins. La plupart des doulas n'ont signalé aucun conflit avec d'autres fournisseurs de soins de maternité; toutefois, à de rares occasions, les doulas ont été tenues à l'écart de la salle d'accouchement par des fournisseurs de soins de maternité, des règlements hospitaliers et/ou administratifs, et (rarement) des clientes. Pratiquement toutes les doulas (98,5 %) ont estimé que leur satisfaction globale au niveau professionnel était bonne ou excellente.

Conclusion : Le fait d'être mieux reconnues et respectées par les autres fournisseurs de soins exerçait une influence significative sur la satisfaction des doulas. Cette étude aide à clarifier les domaines de conflit et les obstacles possibles auxquels les doulas peuvent avoir à faire face dans leur milieu de travail et dans leurs interactions avec d'autres fournisseurs de soins de maternité.

J Obstet Gynaecol Can 2010;32(7):642–649

INTRODUCTION

During the early 1900s in Europe and North America, as births moved from home to hospital, many of the traditional techniques and skills needed to support labour and birth were lost. These were replaced by pharmacological methods of pain reduction, and increasingly from the mid-1970s, by the use of epidural analgesia.[1] The debate about "normal" versus "technical" birth continues,[2–13] with the Canadian Institute for Health Information reporting that in 2004 three out of four women received one or more major interventions during labour.[14] In Canada, the debate over what ought to be considered normal in childbirth has culminated in a joint position paper on normal birth,[15] and in the UK a similar document has been produced.[16] Doula support during labour and birth has the potential not only to reduce the traditional concerns about safety and provide better maternal and newborn outcomes, but also to improve women's sense of fulfillment and satisfaction with the birth experience.[17–21] However, while the doula movement emerged in the early 1990s some difficulties remain for doulas with respect to their integration into the conventional maternity care system.

Doulas are trained and experienced in providing continuous emotional support and reassurance. As part of their training they are taught by their principal professional organization (DONA International) to avoid interfering with nursing, midwifery, or medical care.[22–24] In their antenatal activities, doulas usually inform their clients about the various options, risks, and benefits of the different approaches available in maternity care.[25] While in Canada the costs of services provided in conventional maternity care are covered by provincial healthcare insurance schemes, those provided by doulas are not. Doulas therefore are usually employed directly by women; they are accountable only to their client and do not have professional accountability to any institution or care provider.

We have previously surveyed the attitudes and beliefs of conventional maternity care providers[26] and more recently the attitudes and beliefs of care providers including doulas.[22] In the present study, we sought to examine the perceptions and practices of Canadian doulas to better understand their roles and interactions with obstetricians, family physicians, nurses, midwives, and administrators. We wished to gain an understanding of the motivations behind the decision to become a doula and to gain some understanding of the dimensions of satisfaction derived from working as a doula.

METHODS

For this cross-sectional survey, we developed a questionnaire from published studies on maternity care providers and women[26] and from the DONA International doula certification course syllabus and position papers. A pilot study was conducted with doulas outside the current study to ensure reliability and clarity of the questions. Data analysis was performed using SPSS for Windows, version 15 (SPSS Inc., Chicago, IL). Descriptive statistics were used.

It is difficult to estimate the true number of doulas practising in Canada, as there is no mandatory registration with any doula association. We used the membership list of DONA International as a convenience sample of doulas in Canada, because DONA International is the most recognized organization for the promotion of doula practice, even if those on the DONA list might not necessarily be certified by DONA International. Assisted by DONA, we attempted to contact and send the study questionnaire to 407 doulas across all Canadian regions and Territories.

Ethics approval for the study was provided by the Behavioural Research Ethics Board of the University of British Columbia. Research activities were conducted according to the Tri-Council Policy Statement.

RESULTS

The original mailing and one follow-up to non-respondents generated 212 responses (a response rate of 55.7%). Demographic characteristics of the respondents are shown in Table 1.

The descriptive characteristics of Canadian doula practice are summarized in Table 2. The mean number of births for which doulas provided support during the preceding 12 months was 8.6. The majority of doulas (87.8%) reported that they practised in a community where full specialist support by obstetricians and anaesthetists was available. Only 18% worked in communities where only primary care services were available, without surgical or anaesthetic services on-site. Almost one half of them practised in a community with surgical and anaesthetic support provided by general practitioners, surgeons, or both. Overlaps in the study settings indicate that some doulas practised in more than one type of community. Doulas typically worked primarily in solo practice (63.2%).

The mean number of years in doula practice was 5.1, and 42.5% had from 4 to 10 years of practice experience. Most of the doulas characterized their experiences as good (35.8%) or excellent (62.7%). Three quarters of doulas saw themselves continuing doula work through the next five years, but 5.2% felt that they would discontinue work as a doula during this period (Table 2).

As shown in Table 3, respondents were motivated to work as a doula by their personal interest (73.6%) and their desire to support women during childbirth (89.6%). Ninety-seven percent indicated that enjoyment derived from supporting women in labour was the primary motivator for them to continue working as a doula, while "on-call requirements" were the main reason for plans to discontinue doula work in the future. Of those who responded to the question regarding requirements for continued commitment to doula work, 78.5% cited the need for government or third party support, while 51.3% cited the need for higher compensation levels and 67.7% cited the need for better recognition by other health care providers as important factors. In responding to an open-ended question about what it is like to be a doula in their usual working environment, 105 doulas felt appreciated and expressed gratification; 22 expressed concern over overuse of medical interventions in the hospital; and 18 indicated that mothers' wishes tend to be ignored in the hospital.

Supporting women at home births was the preferred practice for one third of doulas, compared with one quarter who preferred hospital births. In practice, however, 99.5% of respondents indicated that they provided support to women in hospital settings, compared with 81.6% who supported women in home births. One third of doulas surveyed had actually supported more than one birth at home, compared with 95.2% who had supported more than one birth in hospital. Although all the doulas surveyed supported labour and birth, nearly all also provided some level and duration of postpartum support. The mean number of days that doulas followed their clients after birth was 28.6, excluding those who responded "as many days as needed." However, over one half of the respondents stated that they attended to their clients no more than two times during the postpartum period, again excluding those who responded "as many times as needed" (Table 2).

Many doulas acknowledged that they encouraged their clients to ask their doctor to limit certain medical interventions. Of the 94.8 % responding to this question, 69.7% reported encouraging their clients to ask their doctor to limit episiotomy use and 42.3% to delay cord clamping; 79% encouraged their clients to ask their doctor to try non-pharmacological forms of pain relief before administering an epidural. However, the timing of this encouragement to clients (before or during labour) was not captured in the study.

Respondents' feelings of acceptance by others in their work environment differed by discipline. Their perceived acceptance by hospital administrators was lowest (34.1%), followed by that of obstetricians (53.4%), nurses (62%), and family physicians (69.7%). Midwives were cited as the most

Table 1. Demographics of doulas who participated in the study

Characteristics	n (%)
Age	
≤ 30	46 (21.7)
31 to 40	94 (44.3)
41 to 50	43 (20.3)
≥ 51	27 (12.7)
Did not respond	2 (0.9)
Highest level of education	
High school	21 (9.9)
Some college	64 (30.2)
College degree	82 (36.7)
Graduate degree	43 (20.3)
Did not respond	2 (0.9)
Country of origin	
Canada	184 (86.8)
Canada (First Nations)	3 (1.4)
Other	25 (11.8)
Marital status	
Not married	15 (7.1)
Married/partnered	187 (88.2)
Divorced/widowed	10 (4.7)
Have you ever given birth	
Yes	184 (86.8)
No	27 (12.7)
Did not respond	1 (0.5)
When I gave birth I had	
Vaginal birth(s) only	162 (76.4)
Caesarean section(s) only	8 (3.8)
Both	13 (6.1)
Did not respond	29 (13.7)
How many times have you given birth	
1	36 (17.0)
2 to 4	142 (67.0)
≥ 5	6 (2.8)
Did not respond	28 (13.2)
Overall, how would you rate your birth experience	
Very negative/negative	19 (9.0)
Neither negative nor positive	19 (9.0)
Positive/very positive	145 (68.4)
Did not respond	29 (13.7)

Table 2. Descriptive characteristics of doula practice

Characteristics	n (%)
How many years have you been a doula?	
≤ 1	40 (18.9)
2 to 3	55 (25.9)
4 to 10	90 (42.5)
≥ 11	23 (10.8)
Did not respond	4 (1.9)
Approximately how many births did you provide labour support for in the last 12 months?	
0	7 (3.3)
≤ 5	99 (46.7)
≥ 6	104 (49.1)
Did not respond	2 (0.9)
I practice in	
British Columbia	68 (32.1)
Alberta	29 (13.7)
Manitoba	14 (6.6)
Ontario	87 (41.0)
Other	14 (6.6)
I practice in a community(s) with	
primary care services only—without surgical or anaesthetic services on-site	37 (18.0)
surgical and anaesthetic support by general practitioners and/or surgeons	93 (45.4)
full specialist support by obstetricians and anaesthetists	180 (87.8)
I work	
in solo practice	132 (63.2)
in group practice	35 (16.7)
with back-up doula(s)	156 (74.6)
I prefer supporting women in (strongly agree + agree)	
home birth	82 (38.7)
hospital birth	55 (25.9)
In practice, I provide birth support to women	
at home	173 (81.6)
in hospital	211 (99.5)
I provide postpartum support to my clients	
duration: mean days	28.6
frequency: ≤ 2 times	138 (67.0)
I am a member of	
DONA International	212 (100.0)
Association of Labor Assistants and Childbirth Educators	5 (2.4)
Childbirth and Postpartum Professional Association	28 (13.2)
International Childbirth Educators Association	18 (8.5)
other	74 (34.9)

Table 2. continued

Characteristics	n (%)
I am certified with	
DONA International	145 (82.9)
Childbirth and Postpartum Professional Association	13 (7.4)
International Childbirth Educators Association	7 (4.0)
other	44 (25.1)
I have	
trained as a nurse	22 (10.4)
trained as a midwife	6 (2.8)
trained as a medical assistant	6 (2.8)
had formal doula training in a DONA International approved course	206 (97.2)
taken other doula training courses	77 (36.3)
taken formal training to be a child birth educator	68 (32.1)
taken formal training to be a lactation consultant	9 (4.2)
taken formal training to be a breast feeding counsellor	36 (17.0)
taken formal training to be a registered massage therapist	18 (8.5)
taken DONA International training to be a postpartum doula	26 (12.3)
taken other training to be a postpartum doula	16 (7.5)
taken other formal training and continuing education.	77 (36.3)
How accepted do you feel by (well + very well)	
Obstetricians	111 (53.4)
Family physicians	145 (69.7)
Midwives	189 (90.9)
Nurses	129 (62.0)
Hospital administration	71 (34.1)
Overall, how would you rate your experience as a doula?	
Excellent	133 (62.7)
Good	76 (35.8)
Neutral	3 (1.4)
In 5 years, do you see yourself still doing doula work?	
Yes	160 (75.5)
No	11 (5.2)
Undecided	41 (19.3)

accepting group (90.9%). In absolute terms, of the 183 doulas who responded to the open-ended question covering this issue, 72 indicated that they did not perceive that they had been accepted by nurses; 48 felt that they had not been accepted by doctors (obstetricians or family physicians), and 48 reported having experienced acceptance only by physicians, while 20 described non-acceptance by physicians. One third of doulas had been in a situation in which conflicts had arisen between them and other maternity care providers, and in 52.1% of such cases (38 doulas), no resolution was felt to have been adequately achieved.

We found that it has not been unusual for doulas to be asked to leave the delivery room at least once. This included 47.1% of respondents to this question, who indicated that hospital or administrative regulations had excluded them from the birth. Further, 32.1% noted that for various reasons they had been asked by a doctor, nurse, or midwife to leave the women they were supporting, including during epidural administration, in the operating room, and during vaginal assessments. Some of the doulas (15.6%) reported being excluded from labour and delivery by their own client for various reasons, such as a mother's preference to have a family member present instead of her doula. This was usually due to hospital rules that allowed only one support person in the room during various procedures or to other institutional regulations, which put a doula into the difficult position of having to choose between themselves and the client's family support person(s). In rare situations, doulas had chosen to exclude themselves from supporting a client during labour and delivery; 12.3% of respondents declined to support a client because of her preferred hospital. Of these respondents, 17 reported that this was due to travel time to the hospital, and 9 believed that particular hospitals did not respect doulas. Only 14 respondents (8.6%) had declined to support a client because of her choice to have an unassisted home birth.

DISCUSSION

This is the first report of the demographic characteristics of Canadian doulas and their experiences of acceptance into the health care system. Previous research has demonstrated significant decreases in adverse perinatal and neonatal outcomes (Caesarean section, labour pain, fetal distress) when doulas were present during labour.[18,19,21] Further, in the current environment of scarce resources, doulas can play an important role in helping mitigate diminishing human resources in maternal and newborn care. In fact, in many parts of the country where access to midwifery care is limited, an emerging trend is the use of doula–physician based care. This has potential policy implications for institutions and, if the trend continues, highlights a need for more communication and greater involvement of doulas in many aspects of maternal and newborn care. Our study demonstrates the need for such policies.

We believe that doulas' attitudes and beliefs toward central issues in maternity care and childbirth have an effect on these outcomes, and these were the subject of our previously reported study. [22] In that study we demonstrated that there are many Canadian maternity care providers (including 50% of obstetricians) who do not support the activities of doulas or appreciate the capacity of doulas to improve maternal and newborn outcomes.[22] The most unequivocal support for doulas in the study came from midwives, with whom doulas share a philosophical vision of birth and how it should be managed or supported.

While we acknowledge that the health care systems of Canada and the United States are different, we have compared the results of our study with the only comparable research, by Lantz et al., in which 626 certified and certification-in-process doulas in the United States were surveyed (with a 64.4% response rate).[27] In our sample, Canadian doulas were similar in age to their US counterparts, and were somewhat more educated (57% of Canadian doulas had a college or graduate degree, compared with 49.8% of American doulas). Most doulas in our study (88.2%) indicated that they were married or partnered, similar to the proportion in the US study (81.6%), and a similar proportion had ever given birth (86.3% and 87.8% respectively)[27] with the mean number of births reported as 2.4 for Canadian doulas and 3.3 for American doulas.

The type of support a doula provides may reflect her own personal experience of giving birth. Our study found that 76.4% of Canadian doulas had experienced vaginal births only; a small proportion had experienced both vaginal delivery and Caesarean section (6.1%), while an even smaller proportion (3.8%) had experienced Caesarean section only. Positive personal birthing experiences seemed to provide more motivation for becoming a doula (42%) compared with negative experiences (24.1%); the latter served as a motivation to help prevent such experiences from occurring to other women (Table 3). Comparable figures for American doulas were not available.

The most satisfying aspects of working as a doula that we identified were somewhat different from the findings of Lantz et al.: supporting women was deemed to be very satisfying (97.1% compared with 49%); helping clients in childbirth was also deemed to be very satisfying (89.6% compared with 48.2%); and developing relationships with clients, families, and other medical care providers was also satisfying (81.8% compared with 14.4%).[27]

The intention to continue in doula work appeared to be influenced by multiple factors. Most Canadian doulas (78.5%) said that government or third party support would provide

Table 3. Reasons for becoming a doula, continuing, and discontinuing doula practice

Rank	Reasons for becoming a doula	%	Reasons for continuing doula practice	%	Reasons for discontinuing doula practice	%	Factors that could convince to continue doula practice	%
1	I wanted to support women in child birth	89.6	I enjoy supporting women in labour	97.1	On-call requirements	50.0	Government or third partysupport and benefits	78.5
2	My own personal interest	73.6	I love the work	85.9	Difficulty in balancing family demands and obligations	43.5	Better recognition by health providers	67.7
3	I had a positive personal birth experience that I wanted to share with other women	42.0	Attending births is a rare privilege	78.2	Difficulty in balancing doula work with other jobs	38.0	Higher compensation levels	51.3
4	In order to provide support to family and friends	29.7	I have developed relationships with clients	54.7	Moving on to do other birth-related work	33.3	Greater respect	38.5
5	I had a negative personal birth experience that I wanted to help prevent by supporting other women	24.1	I have made this my career choice	42.3	Inadequate compensation	31.5	Other	23.1
6	Other	24.1	I enjoy receiving gratitude and appreciation from clients	40.6	Politics of health care	21.3	Greater responsibility	10.8
7	As a career to earn money	21.7	I need to maintain my certification	27.1	Difficulty in finding clients	19.4		
8	Complements my other practices	19.3	I have developed relationships with medical care providers	27.1	Fatigue/sleep deprivation	17.6		
9	Recommended to do this before applying for midwifery school		It is a good fit with my other practices	24.7	Lack of support and respect from the maternity care providers	14.8		
10			It brings me recognition and respect	21.2	Retirement	12.0		
11			Other	18.8	Personal physical limitation	10.2		
12			I am working with a doula project	7.1	Other	9.3		
13					Provider conflicts	7.4		
14					Fear of litigation	4.6		
15					Not enjoying doula work	2.8		

adequate motivation for them to continue their work, similar to the findings of Lantz et al. (89.4% of certified doulas).[27] Improved respect and recognition by other health care providers (67.7%) and higher compensation levels (51.3%) were among the other major reasons reported as factors that could motivate Canadian doulas to continue practising (Table 3). Lack of support or respect from other maternity care providers was a more important issue in the US study (41.6%) than in the Canadian study (14.8%).

The workload of doulas appeared to be a greater concern in Canada than in the United States, despite the fact that the actual mean number of births supported in the last 12 months was comparable (8.6 births in Canada and 9.3 births in the United States).[27] On-call requirements and fatigue or sleep deprivation (67.6% compared with 22.9% in the study of Lantz et. al.) and difficulty in balancing doula work with family demands and obligations (43.5% compared with 23.9%) were the most challenging aspects of doula work. Although only 21.7% of Canadian doulas indicated that the

decision to become a doula was a career decision influenced by monetary gain, nearly twice as many Canadian respondents expressed concern over inadequate compensation levels when compared with US respondents (31.5% compared with 14.9%).[27] This will require clarification in future studies.

Canadian doulas often reported feeling that medical interventions were overused, and they favoured a more natural or normalized birth experience. According to the DONA International Code of Ethics,[23] however, doulas should not project their values or goals on labouring women. Nevertheless, our results indicate that many doulas encouraged their clients to avoid some medical interventions, even though they are discouraged by the DONA International Code of Ethics from engaging in this type of activity during labour. More information is needed on this point, but our findings suggest that deviation from the DONA Code of Ethics could account for some of the exclusionary practices of conventional practitioners and administrative rules. If misunderstandings are to be resolved, conventional practitioners and administrative representatives need to engage in discussion of these issues outside the heated environment of the maternity suite.

Perceived acceptance by nurses in this study (62%) was close to the experience noted by Lantz et al.,[27] with doulas in the United States reporting 75.6% acceptance by nurses. Canadian midwives were cited as the most accepting among the care provider groups (90.9%). Doulas' roles may have strong synergies with those of midwives, and they may face many of the difficulties that have been faced by midwives before midwifery regulation in Canada. Moreover, in Canada, it is not unusual for doulas to go on to become registered midwives.

One of the limitations of surveys of this type is that it is difficult to discern differences between respondents and non-respondents. We only surveyed doulas in Canada, and the extent to which our findings can be generalized to other settings is unknown. The study relied on self-reports of practices, views, and behaviours, without verification that doulas actually practised in the manner described in their responses. As our study did not capture the timing of advice given regarding the avoidance of certain procedures (prenatally or during labour), this will need to be explored in future studies.

In addition, we did not ask about the timing and level of the initial involvement of doulas during labour. The work of doulas in latent and early labour represents work not usually done by other maternity care providers or supporters, except for midwives. This may cause confusion and conflict when other care providers do not recognize this significant segment of a doula's work that occurs outside hospital. This issue can be explored in future research.

Women's health-seeking behaviours and preferences can be influenced by various psychosocial, economic, personal, and individual factors,[28] including the attitudes of their care providers. Responding to a defined Canadian Institute for Health Information research priority ("to understand what accounts for soaring intervention rates and the role of professional and maternal attitudes"[14]), this study aimed to illuminate the experiences of doulas as part of the maternity care team. The actual experience of Canadian doulas has not been previously studied, so our findings may contribute to a better understanding of doulas within the Canadian system of maternity care. This study identified some of the obstacles that doulas face, and it identified the occurrence of conflicts in their work environment. Doulas' concerns, as expressed in this study, could prove helpful to health care administrators and policy makers in planning and formulating programs, guidelines, and polices for maternity care. These results should provide guidance in policy development, decision-making, and problem resolution regarding the role of doulas within the overburdened maternity care system. Although nearly all doulas reported good or excellent work experiences, receiving more recognition and respect from other care providers was one of the most important factors in potentially enabling doulas to be more satisfied and to continue in this work.

This study highlighted areas of possible conflict concerning labour and delivery practices, as well as potential challenges in inter-professional interactions. We are now in a better position to identify the personal and professional barriers that might impede the further participation of doulas as accepted childbirth workers. A current, as yet unpublished, study has determined the attitudes and beliefs and evidence-based knowledge of women approaching their first delivery (including women's attitudes to doulas) and is comparing them with the attitudes and beliefs of their chosen birth attendant.[22] As a way of improving understanding of the role of the doula and to foster better working relationships between doulas and other care providers, further research with qualitative methodology will be required to examine in more depth the areas of conflict that exist between these two groups.

ACKNOWLEDGMENTS

This research was made feasible through the continued support and assistance of two certified doulas, Ms Kathleen A. Lindstrom and Ms Jalana E. Grant. We would like to express our appreciation and gratitude to them, Mr George Kletas, Dr Rollin Brant, Mr Norman Siu Kee Lo, Dr Ali Mussavi,

Ms Stephanie Chu, Dr Sahel Kooroshnia, Ms Jessica Rosinski, Mr Stephen Hearps, and DONA International for their continued support and assistance during the course of this research project.

REFERENCES

1. Kayne MA, Gruelich MB, Albers LL. Doulas: an alternative yet complementary addition to care during childbirth. Clin Obstet Gynecol 2001;44:692–703.
2. Goer H. The assault on normal birth: the OB disinformation campaign. Midwifery Today Int Midwife 2002;63:10–4.
3. Hook B, Kiwi R, Amini SB, Fanaroff A, Hack M. Neonatal morbidity after elective repeat cesarean section and trial of labor. Pediatrics 1997;100(3 Pt 1):348–53.
4. Klein MC. Quick fix culture: The cesarean-section-on-demand debate. Birth 2004;31:161–4.
5. Klein MC. Obstetrician's fear of childbirth: how did it happen? Birth 2005;32:207–9.
6. Klein MC, Grzybowski S, Harris S, Liston R, Spence A, Le G, et al. Epidural analgesia use as a marker for physician approach to birth: implications for maternal and newborn outcomes. Birth 2001;28:243–8.
7. Leeman L. Family physician and maternity care: high tech or high touch? Birth 1995;22:236.
8. Leeman L, Fontaine P, King V, Klein MC, Ratcliffe S. Management of labor pain: promoting patient choice. Am Fam Physician 2003;68:1023.
9. Leeman L, Fontaine P, King V, Klein MC, Ratcliffe S. The nature and management of labor pain: part II. Pharmacologic pain relief. Am Fam Physician 2003;68:1115–20.
10. Picard A. Natural birth no longer the norm in Canada. Globe and Mail. Friday, Sept 10, 2004;A1.
11. Rosenblatt RA, Reinken J, Shoemack P. Is obstetrics safe in small hospitals? Evidence from New Zealand's regionalised perinatal system. Lancet 1985;2:429–32.
12. Sachs BP, Kobelin C, Castro MA, Frigoletto F. The risks of lowering the cesarean-delivery rate. N Engl J Med 1999;340:54–7.
13. Childbirth Connection. What every pregnant woman needs to know about cesarean section. 2nd ed., rev. New York: Childbirth Connection; December 2006.
14. Canadian Institute for Health Information. Giving birth in Canada: providers of maternity and infant care. Ottawa: Canadian Institute for Health Information;2004.
15. The Society of Obstetricians and Gynecologists of Canada. Joint policy statement on normal childbirth. SOGC CPG No. 221, December 2008. J Obstet Gynaecol Can 2008;30:1163–5.
16. Maternity Care Working Party. Making normal birth a reality. Consensus statement from the Maternity Care Working Party: our shared views about the need to recognise, facilitate and audit normal birth. November 2007. Available at: http://appgmaternity.org.uk/resources/Consensus_Statement.pdf. Accessed November 17, 2008.
17. Hodnett ED, Gates S, Hofmeyr GJ, Sakala C. Continuous support for women during childbirth. Cochrane Database Syst Rev 2007(3):CD003766.
18. Hofmeyr GJ, Nikodem VC, Wolman WL, Chalmers BE, Kramer T. Companionship to modify the clinical birth environment: effects on progress and perceptions of labour, and breastfeeding. BJOG 1991;98:756–64.
19. Kennell J, Klaus M, McGrath S, Robertson S, Hinkley C. Continuous emotional support during labor in a US hospital. A randomized controlled trial. JAMA 1991;265:2197–201.
20. Klaus MH, Kennell JH. The doula: an essential ingredient of childbirth rediscovered. Acta Paediatr 1997;86:1034–6.
21. McGrath SK, Kennell JH. A randomized controlled trial of continuous labor support for middle-class couples: effect on cesarean delivery rates. Birth 2008;35:92–7.
22. Klein MC, Kaczorowski J, Hall WA, Fraser W, Liston RM, Eftekhary S, et al. The attitudes of Canadian maternity care practitioners towards labour and birth: many differences but important similarities. J Obstet Gynaecol Can 2009;31(9):827–40.
23. DONA International. Code of ethics for birth doulas. Seattle (WA): DONA International; 2008.
24. DONA International. Standards of practice for birth doulas. Available at: http://www.dona.org/aboutus/standards_birth.php. Accessed July 7, 2009.
25. Simkin P, Way K. A DONA International position paper: the birth doula's contribution to modern maternity care. DONA International; 2008. Available at: http://www.dona.org/publications/position_paper_birth.php. Accessed April 4, 2010.
26. Reime B, Klein MC, Kelly A, Duxbury N, Saxell L, Liston R, et al. Do maternity care provider groups have different attitudes towards birth? BJOG 2004;111:1388–93.
27. Lantz PM, Low LK, Varkey S, Watson RL. Doulas as childbirth paraprofessionals: results from a national survey. Womens Health Issues 2005;15:109–16.
28. Report of the Fourth World Conference on Women: Beijing, 4–15 September 1995. New York: United Nations;1996.