Giving birth is a parasympathetic process, a physiological condition that requires a feeling of ease, rest, comfort, confidence, and security. When these environmental conditions are not met, anxiety and fear inevitably trigger a stress response that inhibits uterine contractions and increases the likelihood of prolonged, dysfunctional labor (Chapter 7). Parasympathetic dominance in labor is best promoted by a one-on-one female companion and the personal attention of a trustworthy professional who watches over the parturient’s safety and ensures that labor progresses. This is a double-edged sword: the demanding requirements of non-stop presence, personal commitment, and continuous labor support are strongly correlated with a fixed limit on the maximum duration of labor, because neither is possible without the other. Work schedules exceeding 12 hours are unrealistic.

### 16.1 Lack of supportive care

Until 50–60 years ago, childbirth was primarily a woman’s world, one in which women of all cultures were attended and supported by other women during labor and delivery. Over the past 5–6 decades, however, hospitals have replaced the familiar environment of home. Physicians have replaced midwives for low-risk births and nursing staff have replaced female family members as supporters during birth. Childbirth in modern maternity centers currently subjects women to institutional routines, a lack of privacy, unfamiliar personnel, work shift changes, and other conditions as highlighted in Chapter 4 that inevitably undermine the parasympathetic process of birth. These conditions usually have an adverse effect on the physiological course of the labor process, increase the chances of obstetric excess, and set a vicious circle into being.

#### 16.1.1 Discontinuous care

The ability of nurses and midwives to provide unstinting labor support is usually limited by their simultaneous responsibility for more than one laboring woman. Added to this, they may very well begin or end work shifts in the middle of a woman’s labor, usually work in short-staffed institutions, and spend a large proportion of their time managing technology and keeping records (Chapter 4).

Continuous and personal supportive care during labor has become the exception rather than the rule.

#### 16.1.2 Post-modern trends

Legitimate concerns about the “dehumanization” of a woman’s birthing experience in the modern maternity unit have led to calls for a return to home deliveries attended by independent midwives.\(^1\)–\(^5\) This post-modern trend presumes the superiority of autonomous midwifery care during normal labor, but the documented results of formal midwifery-centered childbirth practices argue against...
this proposition (Chapter 5). Unlike the midwives of earlier times – who worked around the clock and stayed with their laboring clients from beginning to end – contemporary midwives have their own family life, disallowing duty shifts longer than eight hours. Additional tasks for other “clients” further prevent them from providing continuous labor support at home or in alternative birth centers. As a result, periodic visits at intervals of three hours or more during the first stage of labor are now common practice in autonomous midwifery care. Clearly this situation is far from ideal and is, in fact, irresponsible, as shown by the Dutch example (Chapter 5). Clearly, advocates of home births should be cautioned not to replace obstetric excess by non-attendance.

Many midwives no longer sit with their laboring clients throughout the entire process of labor, thus nullifying the alleged superiority and safety of their care.

16.1.3 Birth environments

The key issue is not the location of birth – be it the hospital, a primary birth center, or the home – but rather what supports the best chance of a safe and rewarding delivery. Improvement of basic care can only be brought about through radical changes in both secondary and primary care and in the close cooperation between them (Chapter 26). In countries with a fully medicalized childbirth system, the evidence supports midwifery-led care for low-risk women, and obstetricians providing unduly interventionist care should accept this evidence. On the other hand, the often encountered antipathy of fundamentalist midwives against prudent obstetricians is foolish as well.

Apart from territorial disputes between midwives and obstetricians (Chapter 5), the prime necessity for rehumanizing childbirth is adequate and continuous support for women by women during all labors regardless of the place of birth. In addition, every effort should be made to ensure that a woman’s birthing environment is non-stressful, empowering, communicative of respect, private, and not dictated by routines that may be experienced as harsh and add risk without discernible benefit. At the same time, fetal well-being must be monitored and adequate progress must be ensured. These obligatory assessments and measures might be experienced as disruptive, but the consequent potential stress is best counteracted by adequate prelabor preparation (Chapter 19), personal commitment and continuity of care from the provider, and continuous support from a well-informed, female one-on-one companion in labor. The organizational implications of this system will be addressed in Chapter 26.

Not the location of birth, but personal attention, commitment, and continuous support are the key factors in rehumanizing childbirth and providing effective, safe, and rewarding birth care.

16.2 Personal attention and personal continuity

Paradoxically, the tolerance of long labors by conventional midwives wreaks absolute havoc with this basic requirement of continual presence throughout the entire labor and delivery. The midwife attending a home birth should never leave her laboring client. If continuous attendance cannot be guaranteed, then home birth becomes irresponsible (Chapter 5). On the other hand, hospitals must take positive steps to prevent several members of staff from simultaneously attending the same parturient. Personal attention and continuity of care require that every woman in labor has face-to-face attendance by one midwife or one resident who is known to her by name. The provider must appreciate that in every individual case giving birth is a unique life event for each woman, and a casual or impersonal approach is experienced as insensitive and is counterproductive. While a midwife or a resident may attend more than one laboring...
woman, the attention of a nurse is preferably confined to a single patient. Nurses should be selected on the basis of supportive skills and should be trained to be sufficiently aware of the constant need for such skills. A woman’s experience of labor depends largely on the quality of the relationship established with the nurse assigned to her personally. Clearly, “personal attention does not mean a group of nurses caring for an equivalent number of patients on a collective basis.”

In the labor and delivery unit, the nurse’s attention should be confined to one patient only.

### 16.2.1 Mutual dependency

In the final analysis it is the labor room nurses and the midwives who must convert most recommendations into practice (Chapter 26). Although few consultants will dispute the importance of personal attention and continuous support, many continue only to pay lip service to the ideal while taking no interest in the implementation of a labor protocol that truly enables the frontline birth attendants to provide such intensive care. By intentionally limiting the duration of labor to a maximum of 12 hours, the shift changes of the care providers during labor are kept to a minimum. When the rules of proactive support of labor are applied, 80% of all nulliparas give birth within the timeframe of one duty-shift and the disadvantage of the inevitable personal discontinuity in the other 20% is buffered by the knowledge that only one shift change will occur and that the succeeding care provider will follow exactly the same, consistent policy for the conduct and care of labor.

Continuous personal presence and limitation of labor duration are mutually dependent; neither one is feasible without the other.

Reliance on the endeavors of the personal nurse is no excuse for the midwife or physician to stay “back-stage” and to enter the room only on full dilatation or in the event of an emergency. The midwife and physician must also be actively involved and commit themselves to regular assessments of labor progress, the woman’s physical and emotional status, and the well-being of the fetus. A redefinition of the responsibilities and proper working relations between nurses, midwives, and physicians is absolutely mandatory and will be addressed in Chapter 26.

### 16.3 Continuous support during labor

Women report that one of the most disturbing prospects of labor is the fear of being left alone, and unfortunately such fears of isolation are only too well founded in common childbirth practices. Effective provisions must be made to resolve this situation. One-on-one companionship in labor forms the cornerstone of proactive support of labor.

A central feature of proactive support in childbirth is the promise that the woman will not be left alone during her labor at any time.

Mere physical presence is not enough. Supportive care involves eye contact, friendly touch, reassurance, encouragement, consistent information and advice, emotional support, words of praise, comfort measures, and advocacy, which means helping the woman articulate her wishes to the medical staff. The one-on-one female companion in labor – the personal nurse and/or certified doula – carries out this important task.

### 16.3.1 The evidence for continuous support

Continuous support by women for women effectively reduces anxiety and fear and associated adverse effects during labor. The latest systematic Cochrane review of the scientific evidence on continuous support for women during childbirth
clearly proves that women who experience one-on-one supportive care are:

- Less likely to have a cesarean section: (15 trials, \( n = 12,791; \text{RR} = 0.90, 95\% \text{CI} 0.82–0.99 \))
- Less likely to have a forceps or vacuum delivery: (14 trials, \( n = 12,757; \text{RR} = 0.89, 95\% \text{CI} 0.83–0.96 \))
- Less likely to report dissatisfaction with their childbirth experiences: (6 trials, \( n = 9,824; \text{RR} = 0.73, 95\% \text{CI} 0.65–0.83 \))
- More likely to give birth without use of analgesia or anesthesia: (11 trials, \( n = 11,051; \text{RR} = 0.87, 95\% \text{CI} 0.79–0.96 \))
- More likely to have a spontaneous vaginal birth: (14 trials, \( n = 12,757; \text{RR} = 1.08, 95\% \text{CI} 1.04–1.13 \))

The outstanding meta-analysis did not detect any adverse effects and none are plausible. The effects of continuous support were consistently positive in all trials, but the degree of benefit varied among institutions owing to differences in standard practices. Institutions varied in policies as to whether or not routine electronic fetal monitoring was used, whether or not epidural analgesia was available 24/7, whether or not they allowed additional support people of the woman’s own choosing to be present, and whether or not early labor augmentation was standard policy. Indeed, a clear labor management protocol is critical and in fact the whole package of proactive support of labor achieves far more than the sum of its individual components (Chapters 29, 30).

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### One-on-one supportive care during labor has been shown to confer important benefits without attendant risks (Evidence level A).

The Cochrane review included both multiparas and nulliparas and, therefore, the beneficial effects of continuous labor support on first labor outcomes – the main group of interest – were probably diluted. Another systematic meta-analysis by Zhang et al. specifically focused on first labors (4 trials, \( n = 1,349 \)) and all advantageous effects of continuous labor support were demonstrated to be far more pronounced, including a significant shortening of first labor:

#### Beneficial effects of continuous labor support on first labors (Evidence level A)

1. **Shortening of first labors by 2.8 hours on the average (95\% CI 2.2–3.4 hours)**
2. **Reduction of the need for labor augmentation; RR 0.44 (95\% CI 0.4–0.7)**
3. **Doubling of the spontaneous delivery rate; RR 2.01 (95\% CI 1.5–2.7)**
4. **Reduction of cesarean deliveries by half; RR 0.54 (95\% CI 0.4–0.6)**
5. **Reduction of instrumental vaginal deliveries by half; RR 0.46 (95\% CI 0.3–0.7)**

### 16.3.2 Early support

The Cochrane meta-analysis also provides evidence of a “dose–response” phenomenon. A strong and prolonged dose of continuous support is the most effective and the benefits are strongest when one-on-one support begins in early labor. This is an important finding because it confirms and emphasizes the necessity of an early, clear-cut diagnosis of labor and early assessment of uterine effectiveness as discussed in the previous two chapters.

### 16.3.3 One-on-one companion in labor

All trials included in the systematic reviews involved one-on-one support provided by experienced women who had given birth themselves or/and had received education and practiced as nurses, midwives, doulas, or childbirth educators. An additional finding of the Cochrane meta-analysis was that the effects of continuous support appear to vary by type of provider. The effects of continuous support are stronger when the provider is not a member of the staff and thus has no obligation to anyone other than the parturient woman. The reduction in operative births may be less when women receive support from nurses or midwives whose training, role, and/or identity involve responsibilities that extend beyond labor support.
Divided loyalties and duties in addition to labor support as well as the constraints of institutional policies and routines may all play a role. This emphasizes the need for reevaluation of all well-intended nursing rituals (Chapter 4), which will undoubtedly show that many of these can be safely discarded, freeing nurses to focus on their primary task: supportive care.

Continuous labor support is most effective when it begins in early labor and when it is provided by a caregiver who has an exclusive focus on this task (Evidence level A).

The hospital delivery unit should be designated an intensive care area, not with regard to high-tech equipment but rather with regard to intensive one-on-one nursing. But hospital managers advocating “managed care” – and mostly unencumbered by insight into the essential requirements for high-quality childbirth – often preclude such a provision because of lack of funds. These hospital administrators should realize, however, that a substantial reduction in cesarean deliveries translates into an equally substantial reduction in postoperative care, thus freeing nurses to work in the delivery rooms. Good birth care and sound economics can surely complement one another (Chapter 26).

16.3.4 Doula services

Over the past decade several initiatives to employ the services of women with special training in labor support have begun in some countries. This new member of the caregiver team is commonly known as a doula (δούλη is the Greek word for “female slave” or “handmaiden”). She may, however, also be called a labor companion, birth partner, labor support specialist, labor assistant, or birth buddy. In the model pioneered chiefly in middle-class circles in the USA and Canada, the mother selects her doula during pregnancy; they establish a personal relationship that is likely also to involve the woman’s partner, and they discuss the mother’s preferences and concerns before labor. The pregnant woman may have other priorities besides medical help, because she does not leave her work, community, life-experiences, and family responsibilities behind when she enters the hospital to give birth. Her doula has detailed knowledge of the particular circumstances and is, therefore, likely to be in a better position to provide personal care and comfort than unfamiliar hospital staff.

The doula brings her experience and training, often to the level of certification, to the labor support role during childbirth. She rallies the mother’s own powers and improves morale. There are several training workshops and guidebooks to teach nurses and doulas how to help a woman cope with the natural pain and discomfort of normal labor and delivery and to improve her labor environment (Chapter 18). The evidence clearly dictates that there should be serious medical and political efforts not only to promote continuous support of all laboring women by a doula or nursing equivalent but also to provide resources for its universal
implementation. In most places a lot of improve-
ments still need to be made.

Continuous, personal support during labor should be the norm rather than the exception.

16.3.5 Presence of partners and other people

No controlled trials have evaluated the effects of women’s partners, family members, or friends as providers of labor support. Insights into the nature and value of such support have been gleaned from observational studies, but self-selection presents a major problem in the interpretation and the potential for making generalizations on the basis of the results of such studies.21

In practice, hospitals vary greatly in the extent to which they permit people of the woman’s own choosing in labor wards, but it would be imprudent to assume that the presence of several people will provide additional support. Family and friends such as husbands and partners may be there to share the experience rather than to provide support. When there are major tensions in the couple’s relationship, practical and emotional support in labor by the partner may be difficult to provide or to accept. Paradoxically, loving partners may feel powerless and suffer as much as the laboring woman who is experiencing pain and exertion and thus may unwittingly undermine the woman’s ability to cope with labor and delivery. It should be noted that allowing fathers into the labor rooms coincides historically with the staggering increase in the use of epidural analgesia, other interventions, and operative delivery rates. These facts are difficult to reconcile.15 The assumption that rigid policies about the birth environment lead to an increase in interventions may not necessarily be true.15–21 Husbands/partners are often bad doulas indeed.

Nevertheless, the presence of fathers in the labor room is now the norm in most hospitals, and many departments even permit other lay people to be present as well. Indeed, where women have strong preferences for who should be with them at this time, these should be respected. However, given the difficulties of generalizing, the proper policy must be one of sensitivity by the professional staff to the possible negative effects of the presence of fathers and relatives or friends. In some cases, a café around the corner might be a better place for the husband/partner to wait, not only for the sake of the woman giving birth but for the sake of everyone involved. In the labor room women generally have far more to gain from the presence of a female companion who is not only sympathetic but also well-informed and therefore in a much better position to provide the type of firm support and guidance that are needed. Effective support by nurses or doulas, however, is always strongly dependent on a clear and consistent conduct of labor by the midwife or physician. In effect, continuous labor support cannot be implemented unless early correction of dysfunctional labor is performed as well. Contemporary childbirth is teamwork, and teamwork requires an overall, consistent birth-plan: proactive support of labor.

16.4 Summary

- Positive steps are necessary to prevent several members of staff from simultaneously attending the same woman in labor.
- Personal commitment means that each woman in labor is attended face-to-face by one midwife or one resident, who is known to her by name.
- Continuous nursing support on a one-on-one basis during labor should be the norm rather than the exception.
- One-on-one companionship in labor forms the cornerstone of proactive support of labor.
- The evidence shows that continuous labor support by a personal nurse or doula significantly shortens first labors, reduces the need
for labor augmentation, reduces a woman’s likelihood of asking for pain medication, and increases both her chances for spontaneous birth and her satisfaction with the labor experience.

- The benefits of continuous support are strongest when it begins in early labor. This emphasizes the importance of a strict and early diagnosis of labor.
- The requirements of personal continuity and non-stop labor support demand a limit on the duration of labor to a maximum of 12 hours. Neither precondition for a rewarding childbirth experience is feasible without the other. Duty shifts exceeding 12 hours are not realistic.
- The whole package of proactive support of labor achieves more beneficial effects than the simple sum of its components.

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