EFFECT OF DOULA SUPPORT ON WOMEN'S EXPERIENCES DURING FIRST TRIMESTER SURGICAL ABORTION: A RANDOMIZED CONTROLLED TRIAL

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Doulas, lay support people, have long provided support to women during labor and delivery. An extensive amount of research demonstrates that doula support during labor and delivery is associated with improved outcomes such as decreased cesarean section rates, shorter labor, and improved pain management. A new concept of the full-spectrum doula expands the role of the doula to providing support across a variety of reproductive experiences, including birth, miscarriage, adoption, and abortion. Although a large body of research exists on birth doulas, there is limited research on full-spectrum doula support in general, and doula support at the time of abortion in particular. The abortion visit may be an ideal setting for doula support in order to address a number of important clinical and social outcomes. One such outcome is that of pain management, as many women have inadequate pain control during surgical abortion. In the United States, most women undergoing first trimester surgical abortion receive local anesthesia for pain management during the procedure. However, many women who do not receive general anesthesia for first trimester surgical abortion find the procedure very uncomfortable. We partnered with a full-spectrum doula organization to incorporate doula support into a high-volume, urban first trimester abortion clinic in order to address medical and psychosocial needs, including pain management.

The objective of our study was to assess the impact of doula support during the abortion procedure on women's experiences of pain during the procedure.

We conducted a randomized controlled trial, randomly assigning participants to receive routine care (control) or doula support (intervention) during their first trimester surgical abortion. Women presenting to the clinic routinely receive ibuprofen, misoprostol, and a paracervical block with 1% lidocaine before the procedure. Standard procedure in this clinic is to have at least one physician, one surgical technician, and an ultrasound technician in the room during the procedure. Women in the intervention group additionally received doula support consisting of verbal support, hand-holding, massage, breathing guidance, and visualization techniques. We assessed the effect of doula support on women's pain during abortion using a 100-mm visual analog scale (VAS), which is 100-mm line on which participants mark their level of pain (from 0=no pain to 100=worst pain imaginable). Secondary measures included satisfaction, procedure duration, and patient recommendations regarding doula support.

Two hundred and fourteen women completed the study: 106 were randomized to receive doula support and 108 were randomized to receive routine care. The two groups did not differ in regard to demographics, mean gestational age, or obstetric or gynecologic history. Pain scores in the doula and control groups did not differ at speculum insertion (38.6mm vs. 43.6mm, respectively, p=0.184) or procedure completion (68.2mm vs. 70.6mm, respectively, p=0.515). Procedure duration did not differ between doula and control groups. Among women who received doula support, 96.2% recommended that women routinely receive doula support at time of abortion and 60.4% indicated interest in training as a doula. Among women who did not receive doula support, 71.6% of women would have wanted it. Additional clinical staff was needed to provide support for 2.9% of women in the doula group compared to 14.7% of controls.

Although doula support did not have a measurable effect on pain or satisfaction, women overwhelmingly recommended support be included in routine care. Doula support, therefore, may address psychosocial needs of patients.