"A doula is not a visitor...a birth doula is an essential part of the birth team": Interprofessional Dynamics Among Doulas, Doctors, and Nurses

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Abstract

Introduction: Studies have shown that poor birth outcomes are more prevalent among Black birthing people and their babies. Evidence shows that doula care, during labor and delivery, improves maternal and child health outcomes. However there are varying attitudes among doctors and nurses towards doulas regarding taking a collaborative approach with birthing people in labor. Conflict and tension due to doulas may occur in some intrapartum settings in the United States, however this capstone examines these attitudes within the state of Georgia.

Methods: Between November 2020 and January 2021, 17 surveys and in-depth interviews were conducted with doulas in Georgia as part of the community-based participatory Georgia Doula Study, co-led by Healthy Mothers Healthy Babies Coalition of Georgia and academic researchers. The objective of this sub-study was to describe the interprofessional challenges and facilitators of providing doula care in healthcare settings in Georgia.

Results: Doula participants were diverse in age (41% 25-35, 35% 36-45, and 24% 46+) and race/ethnicity (53% white, 41% Black, 6% Latinx). About half (45%) of the participants had a negative encounter with doctors and/or nurses, yet the respondents described positive benefits of when doulas, doctors, and nurses work together. The main themes found were: 1) interprofessional dynamics are unique to each doula and medical care team; 2) doulas are and should be treated as important members of the birth team; and 3) partnerships between doulas and medical/midwifery providers are mutually beneficial but require bidirectional learning and respect.

Conclusion: More research is needed about how doulas, doctors, and nurses can effectively collaborate on the birthing team. It is important to understand that doulas have a specific scope of work and are not meant to overstep into medical care, but they are an essential member of the birthing team providing support to the birthing person. Education for doctors and nurses on the role of doulas and their scope of work is crucial to improve interprofessional dynamics and optimize birth outcomes. To improve maternal and child health especially amongst low-income Black birthing people in Georgia, doula care plays a vital role. Effective integration of doula care—particularly for Black communities in relatively high-mortality regions like the Southeast—has the potential to saves lives, improve equity, and empower birthing people.

"Any woman, any birthing person at all, should be able to choose who they want with them in their birthing space, that's it." –Lisa, a 55-year old White birth doula

Introduction

The Centers for Disease Control and Prevention define maternal mortality as the death of a woman during pregnancy, at delivery, or soon after delivery, resulting in a tragedy for her family and society as a whole" (Centers for Disease Control and Prevention, 2020). Research has shown that Black women are disproportionally affected by maternal mortality (Black Women's Maternal Health, 2018). Research has also shown that Black women are three to four times more likely to die during childbirth compared to White women (Black Women's Maternal Health, 2018). In 2018, the Centers for Disease Control and Prevention utilized data from the National Center for Health Statistics (NCHS), to highlight racial and ethnic gaps within maternal mortality. Data obtained showed that wide racial and ethnic gaps exist. Black women (non-Hispanic) accounted for 37.3 deaths per 100,000 live births, while white non-Hispanic women accounted for 14.9 deaths per 100,000 live births (Centers for Disease Control and Prevention, 2021) . An array of factors contributes to the poor maternal health outcomes presented by Black women. Factors include, but are not limited to, poor access to quality care, systemic/medical racism, socioeconomic status, and other disparities (Howell, et al., 2018). Among the disparities are the lack of education, access to preconception care, hospitals, and prenatal care. The maternal mortality rate can provide information about both maternal and infant health, and it also serves as an important indicator for health overall in the population. Racial disparities in birth outcomes seen nationally are also present within the state of Georgia, with Black birthing people being three times more likely to die from pregnancy related causes than their white counterparts (Platner et al., 2016).

A doula is defined as a birth support personnel who provides both physical and psychosocial comfort to the individual giving birth (Deitrick and Draves, 2008). According to Deitrick and Draves (2008), doula care has been shown to significantly improve birthing outcomes for both the mother and the baby. Improved birthing outcomes include birthweight, gestational age at birth, and method of delivery (Deitrick and Draves, 2008). Further, the continuous birth support that doulas provide has the ability to reduce unnecessary medicalization of births and ultimately improve birth outcomes (Bohren et al., 2017). In a study conducted by Kozhimannil et al. (2016), researchers were able to compare how effective doulas were at assisting in births. They compared doula assisted births to those without a doula throughout the central United States and found that doula care significantly reduced cesarean sections and preterm births in Medicaid beneficiaries. Although the effectiveness of doula care was observed among birthing people, researchers did not take a community-based approach for this particular study.

Community-based research centers the needs of affected communities in the development and execution of research project (Israel et al., 2013). When utilizing a community-based approach, members of the target population engaged throughout all phases of research including during the brainstorming and design of the study; data collection and analysis; and dissemination. Findings from the research are shared—first and foremost— with those members and other stakeholders who may benefit. Community-based studies regarding doula care can engage marginalized groups such as Black women, who are often limited to sources of data during research process, but who also are most vulnerable to poor birth outcomes (CDC, 2020). A community-based approach shows that the researchers share power with the population being researched (Israel et al., 2013). When power is shared among the researchers and those in the

research group, there is increased buy-in from community members and increased capacity to address public health issues (Israel et al., 2013).

Beyond the benefits of doula care observed for birthing outcome, research shows that doula care has specific benefits to disadvantaged marginalized women, who are most at risk for poor birth outcomes (Gruber, Cupito, and Dobson, 2013; CDC, 2020). In 2013, researchers conducted a study that included a sample of mostly Black low-income mothers in North Carolina. Researchers found that mothers who chose to have a doula has fewer birth complications and there were fewer low birth weight babies (Gruber, Cupito, and Dobson, 2013). Evidence shows that Black women highly benefit from doula care but face barriers to access, specifically for low-income Black women (Kozhimannil et al. 2014). Additionally, researchers of the study found that Black women were more likely than their white counterparts to want the support of a doula but not have one (Kozhimannil et al 2014). Beyond their primary roles of supporting the birthing person, evidence indicates that doulas also offer additional support to the partners and families of the birthing person (Steel et al., 2015).

Collins et al. (2021) conducted a study to examine the characteristics and the nature of Black women's interactions with medical providers during childbirth when they were accompanied by a perinatal support person/professional, such as a doula. During the study, 25 in-depth interviews were conducted among Black women who had enrolled in a perinatal support program. During those interviews, participants categorized their personal experiences as positive or negative. The outcomes of those experiences depended on whether medical providers respected them, their birth plans, and collaborated with/respected their perinatal support person. Negative experiences surrounded medical providers having their own individual plan, timeline,

and agenda for the birthing mother. Negative experiences were also associated with one's perceived notation of their needs being ignored, unheard, and/or disrespected.

Researchers found that if participants birthing experiences were what they planned and the medical team respected their birth plan they had positive experiences with their medical providers (Collins et al., 2021). Whereas, if mothers experienced the opposite, they reported a negative experience with medical providers (Collins et al., 2021). Researchers concluded that there was a need for medical providers to set aside their assumptions and value the voices and knowledge of the patient, while also treating their supports as part of the birthing team (Collins et al., 2021; Steel et al., 2015). Participants also stated that when their perinatal support person was disrespected and/or if medical providers did not feel comfortable with them being present, that would indeed make the birthing experience more stressful (Collins et al., 2021).

In a study conducted by Adams, Curtin-Bowen (2021), researchers conducted 43 in-depth interviews with doulas in the United States and found that doulas faced challenges in providing care due to obstetricians attitudes and the power that they held within the hospital setting. Although, doulas shared their challenging experiences, they also reported an improvement in their relationships with obstetricians due to directly challenging their authority, providing educational resources, and creating countervailing responses that involved different maneuvers (Adams, Curtin-Bowen 2021).

Objective

The objective of this capstone is to use qualitative and quantitative evidence from a community-based study in Georgia about interprofessional dynamics between doulas and medical birth care teams including doctors and nurses.

Methods

The Georgia Doula Study was conducted in conjunction with Healthy Mothers Healthy Babies Coalition of Georgia's Doula Access Working Group, which serves as the community advisory board for this capstone. The Georgia Doula Access Working Group includes diverse representation of health professional, doulas, researchers, policy makers, and community leaders. The purpose of the advisory board is to ensure stakeholder engagement in the development of the this community-based analysis.

We conducted a cross-sectional mixed methods observational study including survey data and qualitative data from in-depth interviews. Participants were recruited through emails that were sent to the Georgia Doula Access Working Group. Doulas who were members of the Access Working Group at the time of recruitment were encouraged to participate and share the ongoing opportunity to participate in the Georgia Doula Study. Participants were given $20 for their participation in the study. Inclusion criteria included being over the age of 18, self-identifying as a doula, having worked as a doula in Georgia for at least six months, and proficiency in English.

Seventeen doulas were originally surveyed and interviewed between October 2020 and February 2021. Surveys included questions regarding both the client and doula demographic, changes to services during COVID-19, doula practice, doula reimbursement, and beliefs surrounding doulas and their services. The interview included questions regarding doula training, clientele, practice, doula reimbursement, client stories, and challenges to providing care. In-depth interviews were conducted to collect more detailed information regarding challenges to providing care and client stories. Doula challenges to providing care also include stories

regarding provider collaborations and the dynamics with other members of the birth team – i.e., nurses and doctors.

Interview transcripts were thematically coded using Dedoose, a cross-platform app used for analyzing qualitative data. Transcripts were attentively de-identified, and interviewers completed an interview debrief form that included ten topics of interest and opportunities for reflexivity. Topics obtained were then combined to form a codebook. Transcripts were also coded in Dedoose. Analytic memos were created for major themes and codes of interest such as provider collaborations.

Results

The Sample Characteristics

Participant demographics are presented in Table 1. The 17 doulas participants were 53% white, 42% Black, and 6% were Latinx. Participants were diverse in age with 41% between the ages of 25 and 35, 35% between 36 and 45, and 24% of the participants were 46 or older. Nearly all (71%) of the doulas had at least a bachelor's degree, while 29% had less than a college degree. The majority (88%) of the doulas were not immigrants and, alike, 88% identified as heterosexual. Participants also included doulas who received training from varies bodies. DONA (Doulas of North America) International (35%), Hypnobabies (23%), CAPPA (18%), or other sources (53%) with some doulas having multiple forms of training. Some participants who were also certified received their certifications from the organization above. DONA (Doulas of North America) International (29%), Hypnobabies (5%), CAPPA (17%), or other sources (35%). Most participants provided birth services (82%) and around half reported also offering postpartum (53%) and prenatal services (41%).

Table 1: Demographics of the Doula Sample (n=17)

Variable	Frequency	Percent
Female	17	100
Race/Ethnicity		
White	9	52.94
Black	7	41.18
Hispanic/Latinx	1	5.88
Age		
25-35	7	41.18
36-45	6	35.29
46+	4	23.53
Economic Status		
Prefer not to say/Currently experiencing economic difficulty	2	11.76
Experienced economic difficulty in the past/temporarily in the	5	29.41
Never experienced economic difficulty	10	58.82
Education		
Technical degree/non-clinical professional degree	2	11.76
Some college	3	17.65
Graduated college	8	47.06
Clinical professional degree	2	11.76
Graduate degree	2	11.76
Employment		
Yes, full-time	10	48.82
Yes, part-time	3	17.65
No, not looking for employment	3	17.65
No, looking for employment	1	5.88
Sexuality		
Straight/heterosexual	15	88.24
Bisexual/Lesbian	2	11.76
Immigration Status		
Not an immigrant	15	88.24
First generation immigrant	2	11.76
Ever Been Pregnant	13	76.47
Had a Doula Personally	5	38.46

Table 2: Doula experience, scope of work, training, and clientele of the doula sample in Georgia (n=17)

Variable	Frequency	Percent
Time as Doula		
Less than 1 year	2	11.76
1-3 years	6	35.29
More than 3 and up to 9 years	3	17.65
More than 9 years	6	35.29
Type of Doula*		
Preconception/Fertility	5	29.41
Prenatal	7	41.18
Birth	14	82.35
Postpartum	9	52.94
Abortion	4	23.53
Full Spectrum	5	29.41
Radical/Justice	1	5.88
Death	2	11.76
Training*		
DONA International	6	35.29
Hypnobabies	4	23.53
CAPPA	3	17.65
Other	9	52.94
Certified*	13	76.47
DONA International	5	29.41
CAPPA	3	17.65
Hypnobirth	1	5.88
Other	6	35.29
Sufficiency of Client Load		
Fewer than preferred	11	64.71
Number preferred	5	29.41
More than preferred	1	5.88
Type of Practice		
Solo Practice	14	82.35
Group Practice	3	17.65

*Participants could check all responses that applied

In this sample, we identified 3 major themes about interprofessional dynamics between doulas and medical care teams. These are: 1) interprofessional dynamics are unique depending on each doula and medical care team; 2) doulas are and should be seen as members of the birth care team; and 3) partnerships between doulas and medical/midwifery providers are mutually beneficial but require bidirectional learning and respect.

Interprofessional dynamics are unique to each doula and medical care team

Doulas described how the dynamics between doulas, doctors, and nurses and was unique to each medical care team depending on their prior experiences with doulas and their attitudes toward and knowledge about doulas. For example, some participants shared examples of when medical providers see their worth and express their personal gratitude and appreciation for the work and support that doulas provide.

Andrea[1], a 38 year old Black birth and postpartum doula said:

> *I will say speaking with certain physicians, some of them stress the importance of having a doula, that kind of drove me to even want to get my name out there even more and assist people. Then you have some providers that feel like, if the client has a midwife, then, they don't need a whole birthing team consisting of a midwife and a doula and so forth. I feel like that made me prompt to want to give more information to them [physicians] to have them have a better understanding. I'm not here to be in the way. I'm here to actually help and to help the process of the birth as well.*

Yet there were times when some medical provider did not value the importance of a doula or their role in birth support. One doula shared her example of how a nurse told her doulas are not allowed (citing hospital policy supposedly), and then at shift change, she was allowed in by the next nurse on duty. This demonstrates how nurses' attitudes toward doulas, not actual hospital policy, might be a barrier to doulas in hospital care. Lisa, a 55-year old White birth doula explained,

> *"I know a doula who recently went in and the nurse manager said 'No we're not allowing doulas.' And she hung out in her car until shift change and then she joined her client and*

[1] Pseudonyms were used to protect participants' identities

the new nurse manager said, "Oh, she really needs you." Like, is that yeah. You know, what is that? So you know, this is the discrimination."

The important takeaway from these interviews was that every situation is unique, and doulas do not know how supportive or unsupportive that particular team of doctors and nurses will be. Doulas describe how it's hard for them to provide the needed support to their patients due to medical providers' attitudes and assumptions regarding doulas. Lisa, the 55 year-old White birth doula also explained,

> *I think It's not the doulas that need the education. It's the care providers. I just believe that when we as women take hold of our power, and our rights as birthing people that the people we choose to have with us at our births will not be looked down upon, and will not be the first ones, chosen to be removed from the birthing space. You know, [Birth Center/Hospital D] never has been doula friendly. So it's actually only, [Birth Center/Hospital E] and it's because it was a different hospital that was recently purchased by, [Birth Center/ Hospital D] that allows doulas. But even prior to that, if I went into [Birth Center/Hospital D] when they were accepting doulas.*

Lisa continues by sharing this experience that she had with one of her clients stating,

> *The birthing person and I had to sign an agreement that if they didn't like the way I was providing services they could physically have me removed from the hospital.*

However, Susan, a 48 year-old White full spectrum doula explained;

> *"I haven't had any problem with medical care providers, and I don't know that if that's just because I have a medical background."*

Doulas Are and Should Be Treated as Important Members of the Birth Team

Doulas also described how they are, in fact, members of the birthing team and deserve to be treated as such. Their responsibility is to advocate for their patient and the birthing partner while also providing the needed support. They deserve to have a space in the room. Susan explains her perspective of it all by stating;

> *I don't see it as me, us and them. To me, I consider every member that is responsible for my client, their patient, whether that be the nurse, the hospital, the doctors' office, myself, everybody that's working, we're on the same team. We may not be employed under the same umbrella, we may all be into independent contractors but the big, the final result is we work together to help each other, help our clients [and] patients. So, I'm not afraid to get in the trenches with the nurses. I always tell my nurses when I get in and the doctors, if there's anything I need to do hands on, if I'm not already hands on with my client, I'm not afraid to glove up and clean sheets, change sheets, cleanup floors, anything* ***[non-medical]*** *like that. I think that I see it as a everybody's in it, we're all part of the same team.*

Andrea similarly explained;

> " *I feel like we're essential too because we're essential to the parent that's not only birthing, but to her partner as well. I feel like we should be considered as a part of the birth team. If you think about like when providers come in and they have the fellows and the residents and so forth, like they're able to come in. So, I feel like doulas should be able to come in as well. "*

Mary, a 50 year old White birth and postpartum doula described her feelings towards doulas being seen and treated as important members of the birth team by stating,

"A doula is not a visitor to a birthing woman. A birth doula is an essential part of the birth team. It is somebody who has had a relationship with this woman and her birthing partner for weeks, if not months. I've been hired at five, six and seven weeks of pregnancy. So, I have, been a part of her birth team for perhaps longer than she has seen her OBGYN."

Partnerships Between Doulas and Medical/Midwifery Providers are Mutually Beneficial but Require Bidirectional Learning and Respect

Interprofessional education is needed for all members to truly understand the importance of each of their roles and the importance of peaceful collaboration. Interprofessional education could lead to more networking opportunities for doulas and offer clarification on roles, standards, and increase respect for the each member of the birth team to provide the birthing person and their family the care needed. Brenda, a 37 year-old White birth and postpartum doula describes how she has been able to build her network of clientele while educating other providers,

"At first I went to a lot of the events that care providers had so they would have like meet and greets and a few of them in the area would welcome doulas and all types of birth related workers. So, then I would hand out cards. Some of them at the event they gave a few minutes for people to stand up and sort of say their name and give a little spiel."

Doulas are a win-win for birthing people and to all providers who are providing care, but if doctors and nurses lack the education needed to collaborate they are equally doing a disservice to the birthing person.

"I mean, it shouldn't be a fight in labor to get the things that you want and need. It just shouldn't and there shouldn't be this fear mongering or this territorial [feeling] like this is my patient, you can't be here. This is not a competition. We're all here to support this

person. We all have the same – somewhat same agenda. Hospitals, policies and procedures, not so much. But obviously, as a nurse, you're not here because you want something bad to happen. I'm not here because I want something bad to happen. So, how about we just get on board, on the same page and we both take care of the client in the way we were trained.– Mira, a 26 year old White full spectrum doula (preconception, birth, postpartum, abortion, death)

Mira also provides her expertise on how to improve awareness and the availability of doulas in Georgia,

> *"Honestly, it starts with our hospitals and it starts with providers. I think if more nurses and doctors were pushing for their clients to really research this or providing that educational standpoint, that would be really beneficial. Again, some people have never even heard of a doula. So, how are they going to know [what] to look one up? But then, how do you get those doctors and hospitals to do that? How do you get them on board?"*

Mira, continues,

> *"I would love to see [redacted] who started [redacted]. I would love to see her come to town and have seminars with these hospitals and educate the staff on like the benefits and here's the evidence and here's where we need to start changing policies and procedures."*

Similarly, Imani, a 37 year old Black full spectrum doula (preconception, birth, postpartum, abortion, radical, death) explained,

> *"I would say education. I would say that... education in the physician's world more so[is needed]. Incorporate the benefits of birth workers, midwives, doulas, lactation consultants, breastfeeding consultants and put that into their curriculum, their training.*

So, that they know what the benefits are and that they're able to make good use of us because honestly, we take a load off of the staff. A lot."

Discussion

Although there is limited research regarding provider collaborations and attitudes towards doulas, we see that attitudes may vary. From qualitative analysis, it can be determined that one's personal exposure to individual preferences highly influences their attitudes and beliefs in regard to doulas. Personal attitudes and beliefs interfere with practice and ultimately can negatively and/or positively effects one's birthing experience. It is important to understand that doulas are not the team, they're not there to take over, but they are an essential member of the birthing team providing care to the birthing person. Furthermore, hospitals have to allow doulas in so they can provide the needed emotional and physical support to the birthing person while also being allowed to advocate for what the birthing person wants for their birthing experience.

More exposure to one another during their training and education could help in creating improved positive interprofessional attitudes among those on the birthing team. More exposure could also lead to building openness, a greater respect and appreciation for doulas, and their scope of work. Doulas also have to respect the work of the doctors and nurses by not overstepping, but doctors and nurses also have to allow them to operate in the scope of practice without assuming that doulas are there just to rub the head of the birthing person.

There are some opportunities for partnerships between doulas, doctors, and nurses that could help increase patients awareness and access to doulas. To successfully integrate partnerships we must 1) ensure providers education that includes a focus on collaboration and respect for the work of doulas 2) establish policies that support existing organizations and doulas who are currently doing the work (Ellmann, 2020) 3) implement networking opportunities to

build partnerships and 4) establish that birth is not a medical procedure but a natural process (Quartz, 2015).

The primary strength of this study is its community-based approach. By working with Healthy Mother Healthy Babies Coalition of Georgia and their Doula Working Access Group, the research team was able to ask research questions that address the community's needs including how to improve interprofessional dynamics on birth teams. The primary limitation is the small sample size of 17 doulas in Metro-Atlanta, which does not represent the vast majority of doulas throughout Georgia and beyond. Additionally, although we interviewed and surveyed doulas, there were no interviews and surveys done with their patients nor with doctors and nurses.

In conclusion, more research is needed about how doulas can effectively collaborate on the birthing team with doctors and nurses, including better understanding about doctor and nurse attitudes towards and knowledge about doulas. It may also be important to explore how their attitudes may affect the birthing experience of the birthing person. Education on the role of a doula and their scope of work is crucial for all members of the birth team to improve interprofessional dynamics. There is also a need for policy change in Georgia that providers more opportunities to increase accessibility to doulas care for low-income birthing people especially Black birthing people, who are at highest risk of maternal morbidity and mortality. Doula care is vital to improve maternal and child health especially amongst low-income and Black birthing people in Georgia and beyond.

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