



Hospital-based maternity care practitioners' perceptions of doulas

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Abstract

Introduction: A birth doula provides continuous informational, physical, and emotional support during pregnancy, labor, and immediately postpartum. Existing data on the benefits of doulas, especially for low-resource, high-need patients, do not address how and why individual practitioners decide to recommend this model of care. This project aims to describe best practices of integrating doulas into hospital-based maternity care teams to facilitate access to this evidence-based service for improving maternal health outcomes.

Methods: Semi-structured interviews using open-ended questions were conducted in person with 47 maternity care practitioners—OB/GYNs, family medicine physicians, RNs, and nurse-midwives—across three hospitals. Interview analysis was conducted using the Template Organizing Style qualitative analysis approach.

Results: Results demonstrated varied support for doula care given practitioners' experiences. Positive experiences centered on doulas' supportive role and strong relationships with patients. Some conflicts between practitioners and doulas may stem from a cross-cultural divide between mainstream obstetric/physician culture and a natural birth "counter culture." Suggestions to facilitate good working relationships centered on three overlapping themes: mutual respect between doulas and hospital staff, education about doulas' training, and clarification of roles on maternity care teams especially among staff with overlapping roles.

Conclusions: Among maternity care practitioners, some frustration, anger, and resentment persist with respect to work with doulas. Adequate staff training in the doula model of care, explicit role definition, and increasing practitioner exposure to doulas may promote effective integration of doulas into hospital maternity care teams.

1 | INTRODUCTION

The United States faces a crisis in maternity care, with disparities in maternal child health disproportionately affecting poorer women and women of color.¹⁻⁵ These disparities are particularly evident in cesarean rates, maternal and infant mortality and morbidity, and patient dissatisfaction with birth experiences because of negative interactions with

practitioners.^{1,5-7} Professional societies across family medicine, obstetrics, and pediatrics recognize continuous labor support as effective for optimizing maternal and infant outcomes.^{8,9} A birth doula is a trained health worker who provides continuous informational, physical, and emotional support for patients during pregnancy, labor, and immediately postpartum.¹⁰ The presence of a doula during labor is associated with clinically meaningful benefits, including decreased

	Urban community hospital	Urban academic hospital	Suburban community hospital	Total
Physicians	6	7	3	16
Nurses	3	14	5	22
Midwives	1	4	0	5

TABLE 1 Characteristics of practitioners in study of perceptions of doula care, Rhode Island, United States, 2015-2018

primary cesarean rates,¹¹ higher likelihood of spontaneous vaginal delivery, higher rates of breastfeeding initiation and continuation,¹¹⁻¹⁴ and higher satisfaction with birth experiences.^{12,14,15} Benefits of doula support are significant between racial and ethnic minority groups who experience a disproportionate burden of adverse outcomes.^{6,16-19} Although about 6% of women laboring in the United States work with doulas, a much larger percentage of women who have heard about doulas would like to work with one but cannot⁶ because of barriers such as cost, availability, and access to racially, culturally, and linguistically diverse doulas.¹⁹⁻²¹ Gaps in the literature include how and why individual maternity care practitioners decide to utilize, encourage, or discourage doula care.²² Understanding maternity care practitioners' working relationships with doulas is essential to identify and address barriers to continuous labor support in the hospital.

Interprofessional care teams reduce clinical errors, improve outcomes, and enhance patient satisfaction on labor and delivery floors.^{8,23,24} Little is known about maternity care practitioners' attitudes about doulas and whether they view doulas as interprofessional team members. Conflict between doulas and maternity care practitioners has been documented, especially around medical decision-making.^{18,25-27} A pilot study of patients' perspectives of doula-assisted, in-hospital births found variable willingness among intrapartum nurses to engage with doulas, with reactions ranging from affirmation and acceptance to animosity and resentment.²⁶

This study seeks to describe awareness, knowledge, and attitudes about the birth doula role among the range of maternity care practitioners. It aims to describe best practices for integrating doulas into hospital-based maternity care teams given patients' desire for doula care and the positive impact on maternal health outcomes.^{11-14,28,29}

2 | METHODS

Semi-structured interviews were conducted with maternity care practitioners across three hospitals in Rhode Island, United States, serving different populations and with distinct institutional cultures: (a) a small, urban, community hospital with 450 births/year, a volunteer birth doula program, family medicine and internal medicine residencies, and an obstetric service staffed by obstetricians and family physicians; (b) a large, urban academic hospital with 9000 births/year with an

obstetrics and gynecology residency, staffed by obstetricians; and (c) a suburban community hospital with 800 births/year with emergency medicine, internal medicine, and family medicine residencies, staffed by obstetricians and one family physician. Nurse-midwives practice at all hospitals.

A purposive, criterion-based sampling approach³⁰ was used to recruit maternity practitioners at each hospital: obstetricians and family physicians (residents, fellows, and attendings), registered nurses, and nurse-midwives. For recruitment, we posted study advertisements and recruited in person on maternity units.

The framework undergirding this study is the doula model of care,^{10,22,31} in which trained companions offer continuous physical, emotional, and informational support during times of physical transformation, including to pregnant women during labor and birth.¹⁰ The semi-structured interview guide included 15 open-ended questions supplemented by spontaneous follow-up questions. Questions elicited participants' perceptions of, attitudes toward, beliefs about, and experiences with birth doulas and the doula model of care.

The institutional review board of each hospital approved the study, and written informed consent was obtained. Interviews were conducted in person by one author (KN) between August 2015 and March 2018. Interviews were about 20 minutes long and were audio-recorded and professionally transcribed.

Interviews were analyzed using the Template Organizing Style³² approach. Two authors (KN, RG) created a codebook based on the doula model of care framework, existing literature on doulas, and interview topics. They read each transcript and used the codebook to sort the transcript data along topical categories and emerging themes. They then employed the immersion-crystallization analysis technique³³ to engage in detail with the sorted data to finalize interpretation. Throughout this multistep process, the authors explored divergent interpretations, resolved conflicting perceptions, and reached consensus about final presentation of the results.³³

3 | RESULTS

Forty-three interviews were conducted: five nurse-midwives, 22 labor and delivery nurses (RN), and 16 physicians (five family physicians [FM] and 11 obstetricians [OB]; Table 1). The midwives all had over 15 years of experience; nurses ranged from 2-25 years on labor and delivery; physicians ranged from interns to over 20 years of experience. In total,

seven men were interviewed, all residents or attending physicians. The 36 women interviewed included physicians, nurses, and midwives.

Physicians, nurses, and midwives defined doulas as people who offer support and comfort to laboring patients, and about half identified this role as especially important for patients desiring “physiologic” or “natural” childbirth. The majority identified doulas as lay people, contracted directly by patients and not employed by the hospital. Nurses and midwives were more likely than physicians to explain that doulas received some type of formal training, although most were uncertain about what the training entailed. They also described comfort measures doulas offer, such as rubbing a patient’s back or helping them to shower.

Midwives reflected on the similarities between doula and midwifery training for labor support. Several nurses and midwives referred to the importance of a doula’s role in helping to define or uphold the patient’s birth plan and in fostering an emotional or “heart space” during labor. Some nurses described a doula’s role in the hospital as the role that nurses previously held, “to actually labor with the person,” which nurses can no longer provide because of their added duties: “all the computer rundowns and all the assessments and all the monitoring” (urban-community_RN).

3.1 | Positive interactions with doulas

Across all hospitals, most practitioners described positive interactions with doulas; these centered on the support doulas provide and the value of doulas’ relationships and connections with patients. One nurse described watching a doula and client work together like “a well-oiled machine” (suburban-community_RN). Practitioners of all types described a doula’s presence as “freeing” or making their jobs “easier.” The supportive environment doulas created and maintained allowed medical practitioners to focus on medical and clinical responsibilities, trusting the doula ensured that “there’s no time without emotional, loving care” (urban-community_FM). One family physician described feeling “more confident about the care I’m able to provide and the outcome for that mom and that baby if there’s a doula involved” (urban-community_FM).

About half of all practitioners described experiences partnering with doulas. One family physician shared, “We’re a team taking care—it’s a village. It takes a village to birth a baby” (urban-community_FM). Partnership includes sharing responsibilities (especially nursing duties), helping to fill gaps in supportive care, and sharing ideas and expertise to support the patient. Some mentioned that doulas can be helpful by reframing or educating patients about changes to the birth plan or medical interventions. A few practitioners mentioned doulas may have cultural awareness or language skills for working with immigrant women or those with

limited English proficiency. The benefits of this partnership were especially important for patients hoping for a lower intervention birth.

Family physicians and midwives spoke about the doula’s role in creating empowering birth experiences for the patient. This involves helping to “ground” the patient, facilitating the practitioner-patient relationship, supporting patient decision-making, and empowering patients by engaging the spiritual-emotional aspects of birth. These practitioners recognized “there’s a lot of things that are done that aren’t great to women in labor and their autonomy is removed.” A doula “is kind of like their ambassador” (urban-community_FM) navigating the process of labor and delivery and the hospital context.

3.2 | Negative interactions with doulas

The most common negative or “adversarial” interactions reflected the perception or experience of doulas’ interference with clinical decision-making, including doulas who misinterpreted medical results or were unaware of patients’ medical complexity. Some practitioners described doulas obstructing or delaying medical care and damaging the practitioner-patient relationship. Negative interactions were mentioned by all types of practitioners from all hospitals.

Conflicts often arose in the context of deviations from the patient’s birth plan (because of hospital policy or changes in the course of labor) or doulas communicating the patient’s wishes to the staff. A nurse remarked, “The [doulas] are trying to protect a birth experience so strongly that they may not be seeing the bigger picture” (academic_RN). Physicians primarily described conflict around decisions for cesarean birth, whereas nurses focused on issues about epidurals, monitoring, and position changes.

Perceived challenges to physician decision-making by doulas caused a “resounding negative energy among physicians about doulas” attributed to “when the doula takes over as the voice of the patient and the voice of the physician” (academic_OB). Some practitioners were “frustrated” by the erosion of trust among staff, doulas, and the patient to the point that “there’s no collaboration left.” Some physicians early in their training described feeling disempowered when working with doulas who challenged their decision-making. A few practitioners highlighted that the litigious nature of obstetrics exacerbates these conflicts.

Practitioners described feeling like “the enemy” or “the bad guy” for “doing their jobs” by upholding hospital policies and established labor unit practices that conflict with the doula’s or patient’s preferences. One nurse explained, “To be a caregiver in a professional institution that’s geared to helping a mom have a healthy baby [and] be treated like an enemy the whole time” was “painful” and “awkward” (academic_RN). Some nurses thought this conflict “put patients

in the middle,” forcing patients to choose between following the doula or the medical staff’s recommendations, even when doulas made recommendations outside the local standard of care. One nurse emphasized, “You are in a hospital. We do these things. We take blood pressures. We do interventions... We have to do it. It’s part of our job” (academic_RN).

A few practitioners described effective ways to address conflict with doulas directly:

Whenever I feel a little funky vibe going on I’ll come in the room and just say, “Okay we need to clarify what’s going on and what expectations there are and if you feel those expectations are being met.” And just put it in a very nonconfrontational way but in a way that hopefully will allow everyone to put their needs out on the table. (urban-community_midwife)

For some nurses, the presence of a doula signaled further loss of contact with their patients, in an environment dominated by technology and diminished patient interaction. Others thought the presence of a doula suggested patients’ lack of trust in nurses: “You don’t trust us, and you don’t think I’m going to do a good job. You’ve brought your own person because you don’t [trust me]” (academic_RN).

3.3 | Hospital culture and doulas

Many practitioners discussed the impact of institutional or medical specialty culture on their relationships with doulas. At the urban academic hospital, some physicians and nurses thought doulas were unprepared to handle the acuity of their high-risk patients. Nurses and midwives described an extremely high prevalence of epidural use, and some questioned the utility of a doula in that context.

Midwives focused on birth as a sacred or empowering event and the need to educate patients to assert their right to such an experience, even in a large academic institution.

Is the environment that we have here and the culture that we have a response to what the women in the community wanted? Or are they just reacting to the fact that this is all we’re offering? (academic_midwife)

An obstetrician echoed the sentiment that a shift to maternity care with fewer interventions can be challenging for physicians who are “trained from a somewhat interventional perspective... what you learn over time when you can observe things more globally is that not all interventions are warranted” (academic_OB). Practitioners acknowledged that some patients hire doulas to help protect their birth experience, but a midwife countered that to make lasting change, patients must

“demand a different kind of obstetric care, not bring somebody in” (academic_midwife).

At both urban hospitals, physicians discussed how training in obstetrics versus family medicine might affect practitioner willingness to work with doulas. Labor support “is not something that is taught or encouraged during [obstetrical] training as something that’s important as the physician role,” whereas family medicine residents are “taught to spend much more time with our patients who are laboring” (academic_OB). A few nurses believed labor support is becoming a lost art, especially among younger nurses who rarely attend a labor without an epidural. Doulas were seen by some as potential teachers: “maybe I could learn some techniques from them, too” (academic_RN).

At the urban community hospital, physicians saw doulas as additional care practitioners. Staff were well informed about the role of doulas after years of experience working together. Doulas offered grand rounds on their work, and one physician taught a course on obstetric emergencies to familiarize doulas with issues they might encounter.

At the suburban hospital, practitioners overwhelmingly expressed that they had little to no experience with doulas at their institution and no training to integrate doulas onto their teams.

3.4 | Barriers to doula care

Practitioners identified cost as the greatest barrier to their patients’ ability to access doula care.

In general doulas are super expensive. For patients living paycheck-to-paycheck it just ends up just not even being an option. (suburban-community_FM)

This frustrated some practitioners:

We tell the residents all the time this is level one evidence. It would be great to see it available across the board and not constrained by a person’s ability to pay for it. (academic_midwife)

Physicians described limited knowledge of how to find a doula. Once they identified patients who could use extra labor support, some physicians did not know where to find a doula to recommend, especially one with experience working at their hospital.

3.5 | Suggestions to facilitate good working relationships

The overwhelming majority of practitioners reported being “willing” or “very willing” to work with doulas. Suggestions

to facilitate good working relationships centered on three overlapping themes: education, role clarification, and mutual respect.

Nurses and midwives overwhelmingly cited the need for formal education about doula training, qualifications, and roles, especially for nurses. Overall, practitioners had limited contact with doulas: “People don’t understand the doula” (academic_RN). Most nurses and physicians learned about doulas on the job while caring for a patient who brought along her own doula, either from the doula herself or from colleagues’ comments. One obstetrician remembered, “Doulas probably weren’t introduced in a very positive light by nurses” (suburban-community_OB). In addition, some physicians and nurses thought it would be helpful for doulas to receive training about care of high-risk patients.

Practitioners expressed the need for clearly defined roles for all maternity care team members: “A doula’s idea of maternal support might be completely different from an OB or midwife or a family doctor depending on where you were trained and what’s going on” (suburban-community_FM). Communication about expectations and overlapping roles is important to reinforce the idea that team members are “all trying to get to the same place” of a “healthy mom, healthy baby,” although patients, doulas, and hospital staff may have different cultural perceptions and values about how this is best accomplished.

Maternal support roles for nurses and doulas especially overlap, which can lead to conflict and confusion. Nurses may experience doulas’ suggestions or presence as a challenge to their authority and expertise: “To come in and tell me how to do my job that I feel very passionate about is not acceptable for me” (academic_RN). Lack of knowledge or communication about doulas’ training, qualifications, and role on the team left some nurses feeling unclear about their role when there is a doula in the room:

Do I go over there and rub [the patient’s] back while her husband and the doula are sitting in the chair? Or should I not do that because she’s paying the doula to rub her back? Will that be seen as aggressive? (academic_RN)

Practitioners suggested that meeting or knowing doulas ahead of time could improve relationships and communication.

Practitioners across all sites expressed a desire for mutual respect between staff and doulas to increase trust and decrease conflict. Nurses and midwives wanted their expertise recognized and valued, and to be better understood by doulas. For nurses, mutual respect meant doulas recognize nurses who (a) have expertise in caring for laboring patients: “I went through a lot of training to have my job”; (b) also want to support and care for patients: “We want to do that emotional stuff, but we have to worry about all this technical

stuff”; and (c) have limitations or constraints placed on them because of hospital policies and medicolegal risk: “You as the doula aren’t going to get sued if something goes wrong. But I am” (academic_RN).

Physicians, particularly at the urban academic hospital, discussed the damage that has been done to relationships between doulas and staff. One obstetrician shared that doulas who worked in his hospital “feel like they’ve been burned by this institution in the past.” Another obstetrician mentioned the inherent bias toward doulas because they are seen as “counter to the culture of a hospital environment.” To establish a culture of mutual respect, physicians recommended having structured ways to address disputes or disagreements that might arise, such as

a more contextual framework of how do we provide care, how can we collaborate to enhance the patient’s experience and make sure that all parties are feeling we’re moving in the same direction and have a common goal. (academic_OB)

4 | DISCUSSION

In this study, most maternity care practitioners valued the support doulas offer to patients in the hospitals because, generally, doulas made practitioners’ jobs easier and patients were well supported. However, negative interactions in which doulas were perceived to inappropriately intervene or interfere in medical decisions created barriers to fully integrating doulas into maternity care teams. Practitioners suggested that strained relationships could be improved through mutual respect between doulas and hospital staff, education about doulas’ training, and role clarification, especially among staff with potentially overlapping roles.

Nurses and physicians emphasized the importance of learning more about how a doula is trained to improve their trust in doulas. Doulas’ presence may pose a challenge to the medical hierarchy,²⁵ which is predicated on years of training and experience. The importance of interprofessional education to improve relationships between nurses and doulas has been previously documented.^{27,34}

Interviews highlighted the conflict between many patients’ preference for lower intervention births and hospital policies or cultural norms that make medical interventions more likely.^{1,5} Practitioners described the challenges of negotiating this tension with or without a doula present, but noted that the presence of a doula can exacerbate the tension. Doulas were seen by some practitioners as markers of patient dissatisfaction with hospital care.²⁵ Our findings indicate that conflicts between practitioners and doulas may stem from a cultural divide between mainstream

obstetric-physician culture and a natural birth “counter culture.”²⁵ It is especially relevant to look at how or whether practitioners are trained to work with patients and their doulas as partners in delivering care. Overall, maternity care practitioners in our study who strongly supported physiologic, “natural,” or low-intervention birth were more supportive of working with doulas and were not as threatened by a doula’s presence or suggestions. On the other hand, many practitioners in the study perceived doulas as inflexible in their approach to labor, as evidenced by doulas’ persistent adherence and verbal references to the patient’s birth plan. This raises the question of whether conflict stems from the presence of doulas, or if the problem is more fundamental: Patients are asking for a “lower intervention, high touch” experience that hospitals are not prepared to provide or that may be inappropriate given a patient’s risk factors. Because many doulas are hired precisely to protect that patient experience,^{25,35,36} they can erroneously come to represent the source of this conflict.

The relationship between the doula and the maternity care team is not merely a question of patient preference; it is also a question of health equity. Many women who want a doula are unable to afford or access one,^{6,7,19,21,29} and disparities in maternity care could be mitigated by the presence of birth doulas.^{19,28} Nurses and physicians cite lack of experience as a reason for discomfort in working with doulas. Efforts to improve access to doulas can increase practitioners’ experiences with doulas, improve trust, and enhance collaboration with doulas. Education and role clarification must be important considerations in program development.

4.1 | Strengths and limitations

Although the data in this study are limited to the experience of 43 participants in three hospitals in one state in the same hospital system, this may be partially mitigated by the fact that three different categories of practitioners were interviewed, and each hospital is in a different city. Experiences with doulas may differ by geographic region, or in hospitals or obstetric practices with pre-existing policies on doulas and doula care. Our results correlate with and build on national maternity care discussions^{5,6,19} suggesting that the experience in this hospital system may inform studies of other systems.

4.2 | Conclusions

Doulas can help address the US maternal health crisis by improving birth outcomes, especially among women most at risk. However, negative practitioner attitudes about doulas may interfere with the effectiveness of interprofessional teams. Adequate staff training in the doula model of care, explicit role definition, and increasing practitioner exposure

to doulas may promote effective integration of doulas into hospital maternity care teams.

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