



Fostering Collegial Collaboration Between Labor Nurses and Doulas

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ABSTRACT: Nurses and doulas do not always have positive views of each other. When labor nurses face challenges in their ability to provide continuous labor support, one might believe that a doula would be welcomed, yet this is not always true. Conflicts can arise between nurses and doulas, often because of overlapping roles. However, an optimal health care system is one for which there is an integrated system that fosters collegial interprofessional collaboration. This commentary explores the role of doulas and the care they provide and describes strategies to promote collegial relationships between nurses and doulas.

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I saw a Facebook post that began “Dear Doula, Please, stay out of my way so I can do my job,” and was signed “The Labor Nurse.” I also saw a post on a nursing Listserv that asked about ways to improve cooperation between nurses and doulas. These sentiments as expressed are not isolated. Roth, Henley, Seacrist, and Morton (2016) described the attitudes of nurses and doulas toward each other and found that there appear to be territorial conflicts between these two professions. In this commentary I aim to make the case that nurses should choose to see doulas as their allies rather than their enemies.

Historical Perspective

Labor and birth were once exclusively the domain of the home. In the past, women were cared for during labor by other women, sometimes family, sometimes friends. Some of these layperson caregivers had received some medical training, perhaps as an apprentice to a physician or nurse, whereas others simply learned as they cared for women in labor and birth. Some simply became known in their communities as the most experienced women to assist with birth. Often, they were called a *midwife* or a *lay midwife*.

Nurses should choose to see doulas as their allies rather than their enemies

In the 20th century, birth moved from the domain of the home to the domain of the hospital (Green & Hotelling, 2014; Sosa, Kennell, Klaus, Robertson, & Urrutia, 1980). With this change came the medicalization of birth, and fathers or other support persons were removed from the process (Green & Hotelling, 2014).

In the second half of the 20th century, women began to rebel against the medicalized system and began to demand a more physiologically normal setting, free of drugs and intervention. Fathers, instead of female companions, became a routine part of the birthing environment (Green & Hotelling, 2014). Fathers were often called the *labor coach* yet felt more like a “member of the team” who needed coaching themselves (Berry, 1988; Chee, 2012, p. 21). In fact, both parents reported feeling mental and emotional distress with this arrangement (Steel, Frawley, Adams, & Diezel, 2015). This, in turn, led to more changes in the birthing environment.

Doulas

Sosa et al. (1980) were not the first to use the term *doula*, but their research was the impetus to open the door for a new career path for doulas. Their hallmark research looked at the role of continuous emotional and physical support during labor and the benefits of such care (Sosa et al., 1980). The word *doula* is of Greek origin and denotes a woman who provides care to another woman (Steel et al., 2015). Another definition says that a doula is a woman servant (Maher, Crawford-Carr, & Neidigh, 2012).

In the late 1980s, the first organization to certify doulas for practice was founded, and thus a new profession was recognized (Ahlemeyer & Mahon, 2015). There is debate as to whether doulas are professionals in their own right or paraprofessionals who assist physicians, midwives, and nurses in the provision of care. Regardless of whether doulas are called professionals or paraprofessionals, a layperson fulfilling this role is generally no longer seen because doulas are often trained and paid for their services (Steel et al., 2015).

There is no licensure for doulas in any state; however, Minnesota legislation does provide for registration for certified doulas (Steel et al., 2015). Doulas do not have to be certified to practice their trade (Ahlemeyer & Mahon, 2015). However, certification does substantiate expertise and the capability to



perform the functions of the job (Kaplow, 2011). There are several organizations that certify doulas (see Box 1). Doulas of North America (DONA) International and Childbirth and Postpartum Professional Association have perhaps the most stringent initial education, certification, and recertification requirements. DONA International has the largest number of certified doulas on record. Birth Works International and Childbirth International have less extensive requirements. In fact, Childbirth International has no provision for recertification beyond the original coursework (Ahlemeyer & Mahon, 2015).

Benefits of Continuous Labor Support and Doulas

There are two types of doulas: a birth doula and a postpartum doula (Ahlemeyer & Mahon, 2015; Chee, 2012, 2013). A birth doula provides continuous support during the process of labor and in the immediate postpartum period (Ahlemeyer & Mahon, 2015; Chee, 2012). A postpartum doula provides care during the few weeks after birth, spending variable amounts of time with the new family and assisting with newborn care, household chores, and/or breastfeeding (Ahlemeyer & Mahon, 2015; Chee, 2013). This commentary focuses on labor and birth doulas.

Since the 1980s, there have been numerous studies to examine the benefits of continuous labor support. It is now known that this intervention leads to improvement in birth outcome measures and reduction in health care disparities. Notable potential benefits include lower risk for cesarean birth, forceps-assisted birth, and vacuum-assisted birth; decreased length of labor; less need for analgesia and anesthesia; higher 5-minute Apgar scores in newborns; and greater satisfaction with the birth experience (Strauss, Giessler, & McAllister, 2015).

Kozhimannil, Attanasio, Hardeman, and O'Brien (2013) reported near 100% breastfeeding initiation in their study of

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BOX 1 CERTIFYING ORGANIZATIONS

Birth Arts International

<http://www.birtharts.com>

Birth Works International

<https://www.birthworks.org>

Childbirth and Postpartum Professional Association (CAPPA)

<http://www.cappa.net>

Childbirth International

<http://childbirthinternational.com>

Doulas of North America (DONA) International

<https://www.dona.org>

International Childbirth Education Association

<http://icea.org/certification/birth-doula>

International Doula Institute

<http://internationaldoulainstitute.com>

low-income women who received doula support before and during labor. Women with doula support during labor experience lactogenesis sooner and are more likely to be breastfeeding at 6 weeks postpartum (Gruber, Cupito, & Dobson, 2013). There is also less need for oxytocin augmentation of labor with continuous labor support. This is because as women experience a safe, supportive birth environment, their stress hormone levels decrease, allowing their endogenous oxytocin levels to increase (Green & Hotelling, 2014). Gruber et al. (2013) also reported fewer low-birth-weight neonates in their study of doula support during pregnancy and labor. Likewise, the preterm birth rate is decreased in low-income women with antenatal and continuous labor support (Kozhimannil, Hardeman, Attanasio, Blauer-Peterson, & O'Brien, 2013).

The word *doula* is of Greek origin and denotes a woman who provides care to another woman

Finally, because continuous labor support is associated with fewer interventions in labor, it can lower health care costs associated with those interventions and reduce risk for potential adverse events associated with unnecessary interventions. For example, cesarean births cost approximately 50% more than vaginal births. Therefore, decreasing the cesarean birth rate can reduce overall health care costs while improving health outcomes (Strauss, Sakala, & Corry, 2016).

Labor and Birth in the Hospital Setting

Most women in the United States give birth in a hospital setting (Lothian, 2017; Roth et al., 2016). Nurses are often



thought of by women and families as the major support for a woman in labor. However, research suggests that a nurse's ability to provide continuous labor support is contingent on organizational support to the nurse (Hodnett, Gates, Hofmeyr, & Sakala, 2013). Often, nurse-to-patient staffing ratios do not enable the provision of one-to-one support. In addition, nurses have other duties that require their attention, such as assessments and charting (Zielinski, Brody, & Low, 2016).

Out-of-hospital births are on the rise. Between 2010 and 2014, the rate of home birth increased by 28%. In fact, in 2014 the rate of home birth was the greatest since recordkeeping for this began in 1989 (Crenshaw, Adams, & Amis, 2016). With home birth, a doula's role is focused on emotional support, whereas a midwife's role is focused on the physical aspects of care (Chee, 2012).

Perceptions

One might believe that a doula would be a welcome addition to the labor unit, because labor nurses often face challenges in their ability to provide continuous labor support. However, this is not always true. Nurses are not always receptive to the addition of a doula. Likewise, nurses do not always understand the role of the doula (Roth et al., 2016). Some nurses have not had positive experiences working with doulas. Not all doulas have expert interpersonal and communication skills (Green, 2013). At the same time, many doulas have not had positive experiences working with nurses. Some nurses are adversarial in their dealings with doulas (Steel et al., 2015).

In the literature, the characterization of the relationship between midwives and doulas is contradictory. Some midwives report that they believe that doulas sometimes practice outside of their scope, yet others find doulas' contributions to care to be significant. Generally, midwives have more positive outlooks toward doulas than physicians have toward doulas (Steel et al., 2015).

The doula's natural role as a woman's advocate can often be seen by others as antagonistic. Doulas often feel that they are held responsible when women make an informed choice that is in opposition to what the health care provider or hospital policy suggests (Amram et al., 2014). However, providing information and reinforcing learning from childbirth education classes is within the scope of practice of the doula (Simkin, 2014). Deciding for a woman or forcing one's personal bias on a woman is not within the scope of practice of the doula (Amram et al., 2014).

Roth et al. (2016) provided insight into the characteristics of nurses' and doulas' perceptions of each other. Doulas with higher education and greater household income levels had more positive views of nurses. The opposite seems true for nurses. Nurses who had greater household income levels had more negative views of doulas. Nurses who were certified had more positive views of doulas. Likewise, doulas who were certified had more positive views of nurses. Doulas who worked at only one hospital had more positive views of nurses. Similarly, nurses who had regular contact with doulas had more positive views of doulas. Nurses who had more positive views of labor support had more positive views of doulas. The researchers found geographic differences as well. Nurses in the Western United States had the most positive views of doulas, whereas nurses in the Northeastern United States, Southern United States, and Canada had the least positive views of doulas (Roth et al., 2016).

Strategies to Improve Relationships

It seems that differences between nurses and doulas are inescapable because of the issues of overlapping roles. However, the optimal health care system is one in which there is integrated care within a collegial interprofessional sphere (Amram et al., 2014). Interventions that could be used alone or in combination are described in the following sections (see Box 2).

Consent/Contract Forms

Not all certifying organizations have a specific code of ethics for doula practice; however, some have very detailed guidelines for ethical practice (Ahlemeyer & Mahon, 2015). One intervention for hospitals or birth centers is to create a



type of consent form or contract form to have a woman and her doula sign. The provisions of this consent or contract are the elements of ethical behavior of the doula (see Box 3). Expectations of the doula can be specified, and the consequence for failure to comply with the consent/contract can be delineated. Collaboration with an institutional legal department may be required to review and assist with the creation of this document. Doulas and women may be hesitant to sign a contract. The example provided in Box 3 is taken directly from the ethical standards of practice for doulas. Contracts with other limitations of practice for doulas may be seen as restrictions of trade, which could have legal consequences for the hospital.

Collaboration

Optimal perinatal outcomes begin with collaborative care. Supporting a woman's desire for physiologic birth requires a team effort. Therefore, all health care providers need to approach the care of the woman, her family, and her newborn with an attitude of cooperation (Smith, Peterson, Lagrew, & Main, 2016; Zielinski et al., 2016). The *Interprofessional Education Collaborative (2016)* specifies four core competencies that are essential when discussing collaborative care (see Box 4).

Education is a means of interprofessional collaboration. Hosting educational events, such as labor support training for both nurses and doulas, serves two purposes: it ensures that both groups receive the same training but also allows interdisciplinary communication (Steel et al., 2015). Another means of collaboration is professional conferences, sponsored by groups such as the Association of Women's Health, Obstetric and Neonatal Nursing, Lamaze International, DONA International, or others. Conversations can be started and contact information can be shared (Chichester, 2014). These formal means of collaboration can help members of each group get to know the others on a

BOX 2 STRATEGIES AND TOOLS TO IMPROVE RELATIONSHIPS BETWEEN NURSES AND DOULAS

- Consent/contract forms
- Interprofessional collaboration
 - Formal such as joint education
 - Informal such as networking conversations
- Hospital-based doula programs
- Student-nurse doula programs

BOX 3 TEXT OF SAMPLE CONSENT CONTRACT

This hospital encourages a good working relationship with doulas. A doula may be a paid or unpaid professional. This document helps to outline the role, scope, and function of doulas while they are in the hospital.

The doula's role is to provide continuous physical, emotional, and informational support to mothers and their partners during labor and birth, in a manner as unbiased as possible.

Under the direction of the hospital-privileged physicians, midwives, and nurses, the doula offers support with comfort measures such as breathing, relaxation, movement, and positioning.

The doula understands that hospital-privileged physicians, midwives, and nurses are responsible for assessing the health and well-being of the mother and focusing on the safe birth of the neonate and are the only ones who may diagnose and treat conditions as they arise.

The doula adheres to patient confidentiality in accordance to Health Insurance Portability and Accountability Act (HIPAA) regulations.

Doulas CANNOT:

- Speak for the mother
- Interfere with medical treatment
- Perform clinical tasks such as, but not limited to, vaginal exams, assessing fetal heart tones, adjusting or removing monitors of any type
- Diagnose medical conditions, offer second opinions, nor offer or interpret medical advice
- Make decisions for the woman/client nor project their own values/goals onto the pregnant or laboring woman
- Discourage the mother from her choices, including the choice for pharmacologic pain relief

Our signatures below indicate that we acknowledge and understand the doula's role. We understand that the doula is not an agent or employee of the hospital. We further understand that if the doula does not follow the items in this statement, she/he may not be able to continue her/his support of the pregnant or laboring woman while at the hospital.

Patient Signature: _____

Date _____ Time _____

Doula Signature: _____

Date _____ Time _____

Witness Signature: _____

Date _____ Time _____

personal level but will also assist in the development of trust in each discipline's unique contribution to the health and well-being of the women cared for ([Interprofessional Education](#)

BOX 4 FOUR CORE COMPETENCIES FOR COLLABORATIVE CARE

Competency 1: Values/Ethics for Interprofessional Practice
Work with individuals of other professions to maintain a climate of mutual respect and shared values.

Competency 2: Roles/Responsibilities

Use the knowledge of one's own role and those of other professions to appropriately assess and address the health care needs of patients and to promote and advance the health of populations.

Competency 3: Interprofessional Communication

Communicate with patients, families, communities, and professionals in health and other fields in a responsive and responsible manner that supports a team approach to the promotion and maintenance of health and the prevention and treatment of disease.

Competency 4: Teams and Teamwork

Apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan, deliver, and evaluate patient-/population-centered care and population health programs and policies that are safe, timely, efficient, effective, and equitable.

Source: [Interprofessional Education Collaborative \(2016\)](#).

[Collaborative, 2016](#)). Ideally, this would lead to collaboration during care of women. Explaining care that both nurses and doulas provide and discussing the scope of practice of each can serve to enhance the complementary roles of nurse and doula ([Ahlemeyer & Mahon, 2015](#)).

Collaborations between nurses and doulas can be in formal settings but may also be in informal settings. Networking can occur with simple conversations. Nurses can reach out to the doulas within their geographic areas to begin a dialog ([Chichester, 2014; Waller-Wise, 2006](#)). It may be that doulas who practiced in only one hospital had more favorable views of nurses because they were able to get to know the nurses on a personal level. Likewise, nurses who had more frequent contact with doulas might have had more favorable views of doulas for the same reason ([Roth et al., 2016](#)). Informal collaborations can begin with a single interaction, which, in turn, can lead to more interactions. Nurses can be the ones to reach out to make the initial contact, ask for more explanations of what doulas do, or even invite a doula to coffee ([Waller-Wise, 2006](#)).

Nurses can also support and encourage doulas to become certified. [Roth et al. \(2016\)](#) concluded that the process of certification for doulas gives them the opportunity for interdisciplinary collaboration and education. Nurses can also seek certification for themselves, because the process not only enhances nurses' credibility, but something inherent in the process may bring more open-mindedness to views of the role of the doula ([Kaplow, 2011; Roth et al., 2016](#)).

Often, part of the requirement for doula certification is evaluation by health care professionals (Ahlemeyer & Mahon, 2015). Nurses can volunteer to be mentors for doulas to gain certification, which in turn will add credibility to a doula's practice (Kaplow, 2011). In addition, nurses can encourage coworkers and other health care professionals to be supportive of doulas' certification efforts.

There are many strategies for improving collaboration and communication between nurses and doulas

Hospital-Based Doula Program

Another option that improves relationships between nurses and doulas is a hospital-based doula program. Some programs, such as the one described by Giangregorio (2016), require doulas to be certified, specifically by DONA International, and complete hospital-specific training as well. Devereaux and Sullivan (2013) discuss a multicultural, hospital-based doula program with midwives as the primary care providers during labor. One advantage of an institution- or hospital-based doula program is the control that hospital staff and administration have in the selection, training, regulation, and development of the doula on a professional level (Strauss et al., 2015). Ideally, there would be a shared vision of the care that labor nurses and hospital doulas would provide (Zielinski et al., 2016). However, a disadvantage of a hospital-based doula program is that the hospital may limit the options that hospital-based doulas are allowed to present to women and their families.

Another approach taken to a hospital-based doula program is that of a doula/interpreter. In a Midwestern U.S. metropolitan hospital there is a hospital-based doula program available for Spanish-speaking women in labor. The doula provides the usual emotional, physical, and informational support of a doula but at the same time serves as a medical translator for the woman throughout the entirety of labor. Therefore, these doulas are dual-trained in labor support and medical translation (Maher et al., 2012).

Student Nurse Doula Program

An innovative approach to doula care is that of a student nurse doula program. The Johns Hopkins University School of Nursing offers an elective course called *Community Perspectives on the Childbearing Process* in which nursing students receive a combined total of 24 hours of both didactic and hands-on training to be able to provide continuous labor support to women of low income living in Baltimore. This unique program using student nurses brings a new relationship to the hospital. It teaches student nurses to value the role of the doula. At the same time, the staff in the labor

unit are able to observe the care of both student nurses and doulas simultaneously. Thus, this role supports more positive interactions between doulas and other caregivers (Paterno, Van Zandt, Murphy, & Jordan, 2012).

Conclusion

Nurses and doulas may not always have positive views of each other (Green, 2013; Roth et al., 2016). Territorial conflicts can abound (Amram et al., 2014). The roles of nurses and doulas are not the same, but they are complementary (Ahlemeyer & Mahon, 2015; Green & Hotelling, 2014). The potential health benefits and health cost savings associated with doula care are worth the effort to enhance the relationships between nurses and doulas (Strauss et al., 2016). Several strategies can foster a collegial interprofessional collaborative relationship, including contracts or consents, joint professional education, and social interactions. In addition, hospital-based or student nurse-based doula programs can also bridge the gap between nurses and doulas. Ultimately, the choice of whether a doula will be perceived as an ally or an enemy must be made. Hopefully, the choice will be to use one or more of the strategies outlined to create an ally of the doula for the care of childbearing families. **NWH**



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