ENHANCING INTERPROFESSIONAL COLLABORATION BETWEEN DOULAS, NURSES, AND PROVIDERS IN THE BIRTH SETTING

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# TABLE OF CONTENTS

I. **Abstract** ................................................................................................................................................. 4

II. **Chapter 1 INTRODUCTION** ......................................................................................................................... 5

   A. History and Role of the Birth Doula ........................................................................................................ 5

   B. Benefits of Doula Care ................................................................................................................................. 8

   C. Significance of the Problem and Significance of Enhanced Collaboration ..................................... 9

   D. Summary ...................................................................................................................................................... 10

III. **Chapter 2 REVIEW OF LITERATURE AND EVIDENCE** ................................................................................. 11

   A. Literature Review ....................................................................................................................................... 11

      i. Midwives’ and Doulas’ Perspectives of the Role of the Doula in Australia: A Qualitative Study ........................................................................................................................................ 11

      ii. Midwives’ Experiences of Doula Support for Immigrant Women in Sweden: A Qualitative Study ........................................................................................................................................ 14

      iii. Doula Support and Attitudes of Intrapartum Nurses: A Qualitative Study .................................. 16

      iv. A Systematic Review of Qualitative Evidence on Barriers and Facilitators to the Implementation of Task-Shifting in Midwifery Services .................................................. 17

      v. The Attitudes of Canadian Maternity Care Practitioners Towards Labour and Birth: Many Differences but Important Similarities .................................................. 19

      vi. Defining the Doula’s Role: Fostering Relational Autonomy ............................................................ 19

      vii. North American Nurses’ and Doulas’ Views of Each Other .......................................................... 20

   B. Summary and Limitations of Literature Review ..................................................................................... 21

   C. Conclusion .................................................................................................................................................. 22
IV. Chapter 3 RECOMMENDATIONS FOR ENHANCED COLLABORATION

BETWEEN BIRTH DOULAS AND HEALTHCARE PROFESSIONALS ............ 23

A. Target Population ................................................................................. 23
B. Interventions ......................................................................................... 24
C. Summary ................................................................................................. 26

V. Chapter 4 IMPLEMENTATION AND EVALUATION ................................. 27

A. Prior to Implementation ......................................................................... 27
B. Implementation ....................................................................................... 29
C. Evaluation ............................................................................................... 29
D. Summary ................................................................................................. 31

VI. References ............................................................................................ 32

VII. Table 1 .................................................................................................. 36

VIII. Figure 1 ................................................................................................ 40

IX. Appendix A ............................................................................................ 41
Abstract

Enhancing the interprofessional collaboration between doulas and healthcare professionals is crucial in providing the best care for childbearing women and their families. The purpose of this thesis is to propose a best practice plan for strengthened collaboration between birth doulas and birth professionals, specifically, labor and delivery nurses and providers in the birth setting. Review and synthesis of current research on the relationship between the two roles led to formulation of interventions in the form of a hospital in-service, an informational pamphlet, and a motivational poster. The aforementioned interventions aim to educate healthcare professionals about the role of birth doulas, highlight the importance of enhanced collaboration, and offer recommendations for building positive interprofessional relationships. The interventions included in this thesis are for use in any hospital birth setting where healthcare professionals work with birth doulas. Plans for evaluation of the interventions include using a written questionnaire completed by the labor and delivery nurses and providers in the birth setting.
CHAPTER 1
INTRODUCTION

The purpose of this thesis is to propose a best practice plan for enhanced collaboration between birth doulas and labor and delivery nurses and providers. This chapter provides a review of the history, role, and benefit of the birth doula and the significance of enhanced collaboration between birth doulas and professionals in the birth setting. For the remainder of this thesis, the term ‘doulas’ will be used when referring to labor doulas and/or birth doulas. The term ‘healthcare professionals’ will be used when referring to labor and delivery nurses, midwives, and/or obstetricians.

History and Role of the Birth Doula

Historically, women of almost every culture were surrounded by other women, such as mothers and sisters, when giving birth. Family stories and traditions helped the woman to develop confidence in her own ability to give birth, and female family members offered support and encouragement during the labor process (Green & Hotelling, 2014). When birth was moved from the home to the hospital setting during the early 20th century, much of that support was lost as the care for the mother shifted to nursing staff members who could not always stay continuously with one woman throughout the labor. As a result, women often labored alone (Green & Hotelling, 2014). Maternity care became more medicalized and families began to live further apart in industrialized countries, so a need for support from other caregivers emerged (Campbell-Voytal et al, 2011). The modern birth doula is the manifestation of the support that women used to provide for laboring mothers when birth was treated like a physical and emotional occasion rather than a medical event.
The word ‘Doula’ is an ancient Greek-derived term for a “woman who serves”, and is now a term used to refer to trained individuals who provide continuous non-medical physical, informational, and emotional support to women before, during, and after birth (DONA International, 2005b). DONA International, a non-profit organization of doulas, was founded in 1992 when a small group of childbirth experts decided to promote the importance of emotional support for mothers and their partners during the birth and postpartum period. These experts created an association for a new group of professionals -doulas- that strive to help childbearing families have satisfying birth and postpartum experiences (DONA International, 2005a). DONA International was formed to provide collegial support and standardize training and certification for doulas (Campbell-Voytal et al, 2011). In addition to DONA, other organizations that train and certify doulas exist, including: Childbirth and Postpartum Professional Association (CAPPA), the Association of Labor Assistants and Childbirth Educators (ALACE), Childbirth International, and the International Childbirth Education Association (ICEA) (Campbell-Voytal et al, 2011).

As outlined by the DONA International, a birth doula

- recognizes birth as a key experience the mother will remember all her life;
- understands the physiology of birth and the emotional needs of a woman in labor;
- assists the woman in preparing for and carrying out her plans for birth;
- stays with the woman throughout the labor;
- provides emotional support, physical comfort measures and an objective viewpoint, as well as helps the woman get the information she needs to make informed decisions;
• facilitates communication between the laboring woman, her partner and her care providers;
• perceives her role as nurturing and protecting the woman's memory of the birth experience;
• allows the woman's partner to participate at his/her comfort level (2005b).

Birth doulas remain with the mother throughout the duration of her labor and provide continuous care through physical, emotional, and informational support (Green & Hotelling, 2014). Physical support includes position changes or comforting measures that facilitate the mother in relaxing during and between contractions, such as: breathing; relaxation; movement and positioning; touch; hot or cold packs; beverages; warm baths and showers (DONA International, 2005c). Emotional support consists of strategies that improve the mother’s emotional feelings during and after the birth, thus providing her with a sense of accomplishment and confidence in her role as a mother (Green & Hotelling, 2014). Simple emotional support strategies used by birth doulas in the USA and Canada include reassurance, encouragement, praise, and explaining. These are also strategies utilized by other members of the birth team, such as obstetric nurses or midwives. Complex emotional support strategies employed uniquely by doulas are acceptance, reinforcing, reframing, mirroring, and debriefing (Gilliland, 2011).

Informational support consists of assisting the mother and partner in obtaining information from the healthcare professionals, which allows them to make informed choices about their care (Green & Hotelling, 2014). Although doulas are advocates for their patients, it is not within their scope of practice to perform medical assessments, diagnose medical conditions, or give medical advice (DONA International, 2015c).
**Benefits of Doula Care**

A 2013 Cochrane review involving 23 trials from 16 countries and more than 15,000 women found that women who had continuous labor support were more likely to give birth spontaneously and without surgical or instrumental interventions like vacuums, forceps, or Cesarean-sections (Hodnett, Gates, Hofmeyr, & Sakala, 2013). In addition, women with continuous support had shorter labors, were less likely to use pain medications including epidurals, and were more likely to be satisfied with their birth experience. The newborns of these women were less likely to have low five-minute Apgar scores (Hodnett et al., 2013). The review found that in addition to the many benefits, there were also no adverse effects found in having continuous labor support (Hodnett et al., 2013). The Hodnett et al. review concluded that all women should have continuous support during labor provided by hospital staff, doulas, relatives, partners, or friends. However, they further state that “Continuous support from a person who is present solely to provide support, is not a member of the woman's social network, is experienced in providing labour support, and has at least a modest amount of training, appears to be most beneficial” (Hodnett et al., 2013, p.6).

Women with doula support were also found to have significantly higher rates of breastfeeding intent and early initiation of breastfeeding (Mottl-Santiago, Walker, Ewan, Vragovic, Winder, & Stubblefield, 2008). Kozhimannil et al. (2013) found that doula care during birth supports a near-universal breastfeeding initiation rate among low-income women (Kozhimannil, Attanasio, Hardeman, & O'Brien, 2013). Women who utilized doulas during birth had a 97.9% initiation rate in comparison to 80.8% of the general Medicaid population (Kozhimannil et al., 2013).
In addition to physical and psychological benefits of having continuous labor support, there is also a cost benefit of having a doula. Pilliod et al. (2013) found that when the doula cost was kept below $159.73 per birth, publicly funded doula care, resulted in cost savings to the taxpayer (Pilliod, Leslie, Tilden, Page, & Caughey, 2013). Another study by Kozhimannil, Hardeman, Alarid-Escudero, Vogelsang, Blauer-Peterson, & Howell (2016) concluded that coverage reimbursement for doula services would likely be cost-saving for state Medicaid programs (Kozhimannil et al., 2016). Because cesarean births cost twice as much as vaginal births, providing doula services that could reduce the rate of C-sections would be a cost-effective intervention (Kozhimannil et al., 2016).

**Significance of the Problem and Significance of Enhanced Collaboration**

Although there is a growing body of literature outlining the various potential benefits of continuous labor support provided by birth doulas, the role of the doulas is still not widely embraced in the typical hospital birth setting due to lack of understanding about the doula role and negative interactions between doulas and healthcare professionals (Ballen & Fulcher, 2006). This may be augmented by the fact that many times the doula is perceived as an unfamiliar part of the birth team. Although some hospitals directly employ doulas, most labor doulas practice independently. Therefore, admission for birth may be the first time that the doula and the healthcare professionals—nurses, midwives, and physicians—meet. Although all members of the birth team share the goal of an optimal birth outcome, healthcare professionals and doulas often mistrust each other (Ahlemeyer & Mahon, 2015).

It is essential that doulas and healthcare professionals respect each other’s roles and work together as a team in order to provide the best care for childbearing women and their families. Conflict between the two is not only undesirable, but may also have detrimental effects on the
mother. According to Gilliland, conflict in the birth setting may undermine the woman’s confidence in her doula or medical providers (2002), which could result in tension or anxiety. This, in turn, can have negative effects on the emotional and physical well-being of the mother and fetus (Papagni & Buckner, 2006). Therefore, it is imperative that doulas and healthcare professionals work together harmoniously in the birth setting.

Summary

With the industrialization of countries and the medicalization of birth, the historical labor support provided to mothers by other women who were familiar with the birth process was lost, resulting in a need of continuous support from a new source. Labor doulas can fill in this gap in care by providing continuous emotional, physical, and informational support to mothers before, during, and after birth. A growing body of evidence shows that there are various benefits and no harms that result from the continuous labor support that doulas provide. However, healthcare professionals are hesitant about working with labor doulas due to misunderstanding from both parties. It is essential to identify the causes of the strained relationship in order to enhance the collaboration between doulas and healthcare professionals and therefore promote the best maternal-newborn outcome.
CHAPTER 2
REVIEW OF LITERATURE AND EVIDENCE

Modern research about the relationship between birth doulas and healthcare professionals is reviewed in this chapter, in order to develop a best practice protocol for enhancing the relationship between doulas and other professionals in the birth setting. Articles included in this section were collected using the PubMed and CINAHL online journal database, and were organized by the significance and relevance of the researcher’s findings. All journal articles were peer reviewed. Due to the limited research about the subject, the majority of the articles presented are qualitative studies.

**Literature Review**

**Midwives’ and Doulas’ Perspectives of the Role of the Doula in Australia: A Qualitative Study**

Stevens, Dahlen, Peters, and Jackson (2011) sought to explore midwives’ and doulas’ perspectives of the role of the doula in Australia. Doulas are relatively new in Australia, and due to this there are no standards or regulations for doulas. Anyone can call themselves a doula regardless of the extent of training that they have had. In addition, they are not obliged to register with any professional regulating body (Stevens et al., 2011). Because of this lack of regulation, the role of the doula in Australia is unclear and has led to conflict between doulas and healthcare professionals (Stevens et al., 2011). This research aimed to identify midwives’ perceptions of the role of a doula, identify how doulas see their role, provide insight into what contributes to these perceptions, identify the implications of these perceptions, and increase midwives’ understanding of the role of a doula (Stevens et al., 2011).
The researchers chose a qualitative study design using focus groups, which have been shown to enhance participant retention rates and provide a larger amount of oral information (Stevens et al., 2011). They used a convenience sample of five to six participants per focus groups for a total of two midwife focus groups composed of eleven midwives and one doula focus group composed of six Australian doulas (Stevens et al., 2011). In order to be eligible for participation, the midwives needed at least three years of midwifery experience, be currently practicing, and have worked with doulas. Doulas were required to be currently practicing and had a training that lasted at least three months. In addition to these requirements, both doulas and midwives could not have worked in the opposite role (Stevens et al., 2011). The focus groups were facilitated by two researchers that asked the participants a series of questions based on a pre-written question sheet. The provided data was digitally recorded, transcribed, and analyzed using thematic analysis (Stevens et al., 2011).

Stevens et al. (2011) found that the common theme amongst the focus groups was Australia’s broken maternity system, which they described as “fragmented, overloaded and medically dominated” (p. 511). According to both doulas and midwives, this system is failing women and midwives by not allowing midwives to provide woman-centered care. The doulas perceived that they are filling a gap in childbirth care by providing a continuity of care that midwives are not allowed to give in the current system (Stevens et al., 2011). By providing continuous emotional and educational support, advocating for women, and providing breastfeeding advice, they are filling in this gap in care (Stevens et al., 2011) However, the researchers also found that midwives perceived that doulas were taking their role in the maternity setting by “reducing their role to that of an obstetric nurse” (Stevens et al., 2011, p.512). Midwives reported that the doula changed the dynamic of the midwife-mom relationship and made them feel like
intruders, that sometimes the doulas manipulated the women into not trusting them, and that doulas sometimes overstepped their boundaries by providing the mother with misinformed or inappropriate advice (Stevens et al., 2011). The midwives also reported their belief that doulas hold the power at births because they can influence the laboring woman’s birthing choices, which sometimes made the midwife’s job more difficult (Stevens et al., 2011).

According to Steven et al., the conflicting perceptions of the doula’s role were a source of conflict; however, both doulas and midwives in the focus groups saw a potential for collaboration (2011). Some midwives praised the care that doulas provide for women, and doulas revealed that they are advocates for midwives and feel disappointed that the midwives cannot provide the woman-centered care that they would like (Stevens et al., 2011). According to Steven et al., “both doulas and midwives acknowledged that they strive for the same outcome – the best for the woman and her infant” (2011, p.513), and that in order to facilitate a harmonious working relationship, both roles were willing and eager to meet with each other (2011). In addition, some midwives stated that they believed conflict could be reduced further with the regulation of doulas in Australia (Stevens et al., 2011).

Results from this study suggest that although the relationship between doulas and midwives may sometimes be strained, there is potential for collaboration since both roles want the best outcome for their customer. Furthermore, conflict could be reduced by increasing the familiarity between doulas and midwives, and by regulating the role of the doula in the birth setting.
Midwives’ Experiences of Doula Support for Immigrant Women in Sweden: A Qualitative Study

The objective of this study conducted by Akhavan and Lundgren was to “describe and analyze midwives’ experiences of doula support for immigrant women in Sweden” (2012, p.80). Doulas are rare in Sweden, and due to this there is little research about the benefit of doula support to immigrant women or their value to Swedish practitioners (Akhavan & Lundgren, 2012).

This research was a qualitative study. Ten midwives who worked in maternity healthcare in western Sweden were interviewed. All of the midwives had at least two years of experience, and five midwives had more than twenty years of experience. All of the participants had experience working with immigrant women at the hospitals where they were employed (Akhavan & Lundgren, 2012). The researchers asked the midwives what doula support meant to them while working with immigrant women, what it was like working with a doula and immigrant childbearing women, and their views on the Swedish maternity healthcare and doulas in the setting. The interviews, which lasted between 40-60 minutes, were all tape recorded and transcribed. The data was then analyzed using content analysis (Akhavan & Lundgren, 2012).

Akhavan & Lundgren derived three main categories of findings from the data: (1) ‘A doula is a facilitator for the midwife’… (2) ‘Confident women giving support,’… [and] (3) ‘Doulas cover shortcomings’ (2012, p.80).

The midwives stated that doulas were facilitators to their work of care, and that they viewed them as assets instead of competitors in the birth setting. The midwives felt that the doulas collaborated positively with them in the birth setting, and that they were competent and knowledgeable about the birth process (Akhavan & Lundgren, 2012). Some midwives stated that
they felt left out when the doula and the laboring woman spoke in a common language, but also stated that in the case where the midwife and mother did not share a language, the doula was very helpful to the midwives (Akhavan & Lundgren, 2012). When comparing the role of the doula as a facilitator versus an interpreter, the midwives stated that doulas offer the support and encouragement that interpreters do not give women in the birth setting, and are therefore more interactive than hospital translators (Akhavan & Lundgren, 2012).

The doulas were also perceived as confident women in the birth setting, and were seen as a valuable source of support that conveyed peace and had the woman in her focus. According to the participants, it is important that doulas be confident, but not self-assertive. They also believe that in addition to making the woman feel safe, the doula should be engaged with the woman in labor (Akhavan & Lundgren, 2012).

Finally, Akhavan & Lundgren found that the midwives believed that doulas played a role in overcoming shortcoming in the Swedish maternal health system, specifically in relation to cultural competence (2012). A main complaint was the lack of continuity of care in the medicalized maternity system, and midwives felt that doulas protected the quality of maternal care by providing continuous support to women. Another complaint was the “lack of cultural competence in a multi-ethnic society” (Akhavan & Lundgren, 2012, p.83), along with the affirmation that “doulas can help midwives understand the cultural differences regarding birth (p.83).

The results of this research showed that midwives experienced doulas as facilitators when working with immigrant women in the birth setting. In addition, the results show midwives perceive that doulas overcome shortcoming in the maternity care system by relieving pressure on the midwife, being in the delivery room throughout the labor and childbirth, and filling
communication gaps between midwives and mothers who do not share a language or culture (Akhavan & Lundgren, 2012). Finally, the participants stated that continuity of contact between the doula and the woman before, during, and after labor is a vital part of the doula support system (Akhavan & Lundgren, 2012).

**Doula Support and Attitudes of Intrapartum Nurses: A Qualitative Study**

Papagni and Buckner (2006) understood that although the roles of intrapartum nurses and doulas are very different, a relationship based on mutual respect is necessary to serve childbearing women best. In this study, Papagni & Buckner sought to examine the level of acceptance for doula support shown by intrapartum nurses as perceived by the childbearing woman (2006).

Because little research about the relationship between doulas and intrapartum nurses exists, the researchers chose a qualitative approach. The study involved English-speaking women who utilized the services of a doula and gave birth to healthy newborns in an Alabama hospital. The women were recruited by their doulas, who asked them to reach out to the researcher via call or email if they were interested in participating in the study (Papagni & Buckner, 2006). Eleven interested women received an email with eight interview questions approved by a professional panel. Of the eleven that received a questionnaire, nine women completed and returned it. The responses were analyzed for themes by the investigators and reviewed for validity by a panel of experienced researchers including a registered nurse, a doctoral student, and a nurse educator (Papagni & Buckner, 2006).

The researchers divided the levels of acceptance toward doula support offered by intrapartum nurses into two themes: 1) Acceptance and affirmation; and 2) Resentment and animosity (Papagni & Buckner, 2006). The five participants that perceived their nurse as
accepting and affirming of their doula described the relationship in terms that highlighted the positive collaboration between both roles, using phrases such as “cooperative”, “worked well together”, and “got along very well” (Papagni & Buckner, 2006, p.14). When the doula-nurse relationship was categorized into this category, the women described their birth experience positively (Papagni & Buckner, 2006). In contrast, the four participants who perceived their nurses as resentful or full of animosity towards the doula not only had a negative birth experience, but described the interprofessional relationship very negatively, expressing that it felt “hostile”, “confrontational”, or that there was “no relationship at all” (Papagni & Buckner, 2006, p.14).

Papagni & Buckner also found that the participants all described their doulas as calm and respectful and that none of them reported that their doula’s support interfered with the care from the nurse. Therefore, in the case of this study, the nurses’ resentment and animosity was not attributed to intrusive attitude from the doula (Papagni & Buckner, 2006).

**A Systematic Review of Qualitative Evidence on Barriers and Facilitators to the Implementation of Task-Shifting in Midwifery Services**

Colvin, de Heer, Winterton, Mellenkamp, Glenton, Noyes and Rashidian (2013) conducted a systematic review of qualitative research using a 4-stage narrative thesis approach. The authors wanted to identify barriers and facilitators to task-shifting, or the distribution of tasks between different healthcare roles (Colvin et al., 2013). The researchers included data regarding midwifery services in a low-, middle-, and high-income countries, with participation of various professionals such as: “midwives, nurses, doctors, patients, community members, policymakers, program managers, community health workers, doulas, traditional birth attendants and other stake holders” (Colvin et al., 2013, p.1211).
Amongst various findings, the researchers found that a number of studies often described difficult relationships between midwives and doulas or other birth supporters. The presence of these supporters often changed and complicated the relationship between mothers and midwives by pushing them into a medical role and taking away their support and advocate role (Colvin et al., 2013). Conflict emerged between doulas and midwives when the latter felt that they were being disrespected or not heard. A study even reported a claim of verbal and physical violence between birth professionals, including midwives, and doulas (Colvin et al., 2013). Colvin et al. found that although not all the interactions between the two roles produced tension, the relationships generally disrupted the ideal midwifery model of singular care (2013).

Furthermore, the findings showed that although mothers did not show preference towards a particular birth care provider, they did show preference for a particular birth supporter. A series of studies found that women in vulnerable populations preferred the cultural familiarity of the doulas over midwives as birth supporters (Colvin et al., 2013).

In regards to teamwork and task shifting, the researchers found that several studies described conflicts between midwives and birth supporters with midwives asserting their medical authority and even scapegoating birth supporters for poor maternal outcomes (Colvin et al., 2013). The researchers concluded that healthcare workers should be well-informed on the general scope of practice of midwives, as well as task-shifting or any changes in practice. The relationships between doulas and midwives can be contentious, so clearer definitions of roles, liabilities, and responsibilities are important for a successful relationship (Colvin et al., 2013).
The Attitudes of Canadian Maternity Care Practitioners Towards Labour and Birth: Many Differences but Important Similarities.

In this study, the researchers sought to examine the different attitudes of Canadian maternity care practitioners towards labor and birth (Klein et al., 2009). Klein et al. surveyed 549 obstetricians, 897 family physicians (400 antepartum only, 497 intrapartum), 545 nurses, 400 midwives, and 192 doulas who answered 43 Likert-type attitudinal questions on various subjects (Klein et al., 2009).

Amongst other findings, the researchers found that midwives agreed with labor support more than obstetricians, who were neutral towards this subject. Other disciplines had positive attitudes towards doulas, but about a quarter of nurses and family physicians reported scores that suggested unfavorable attitudes towards doulas. The only outliers who strongly opposed doula support were family physicians who provided antepartum care (Klein et al., 2009).

The researchers had previously found that conflict between doulas and healthcare professionals existed, but noted that this issue did not seem to affect midwives to the same degree as other healthcare professionals (Klein et al., 2009). They also found that, in some cases, the doulas went beyond their scope of practice, which may have contributed to the negative views of doulas by maternity care professionals. This issue of inappropriately taking on the role of the advocate is a sign for a need for clarification on the doula’s role as a support person rather than an advocate (Klein et al., 2009).

Defining the Doula’s Role: Fostering Relational Autonomy

Meadow aims to develop a theoretically grounded model of the doula’s role to guide constructive practice and refute some organizations’ training of the doula’s advocacy role, which can lead to inappropriate practices (Meadow, 2014). Meadow states that doulas have been
criticized for not only interfering with the relationship between healthcare professionals and mothers, but also for imposing their own agenda on their clients (2014). She proposes the application of the relational autonomy framework, which could eliminate the lack of clarity over advocacy and even facilitate the relationship between the medical caregiver and the doula.

The theoretical concept of relational autonomy is an adaptation of the concept of autonomy that integrates the social influences that partners, families, peers, and healthcare professionals have over the women’s birth choices. This framework recognizes that women do not make choices in isolation and emphasizes their skills development, self-confidence, and recognition of the social context (Meadow, 2014). According to Meadow, “highlighting these aspects of exercising autonomy reduces the potential for the doula to seek to influence her client. The doulas role is reframed as one of facilitating patient engagement and shared decision making” (2014, p.3057).

North American Nurses’ and Doulas’ Views of Each Other

In this multivariate analysis of a cross-sectional survey, the authors aimed to analyze that factors that lead doulas and nurses to have positive views about each other (Roth, Henley, Seacrist, & Morton, 2016). A multiple regression analysis was used to examine the Maternity Support Survey, which is an online survey with labor and delivery nurses, doulas, and childbirth educators in the United States and Canada (Roth et al., 2016). The authors used a convenience sample of 704 nurses and 1,470 doulas (Roth et al., 2016).

The authors found that nurses had more positive views towards doulas when they were exposed to doulas in their primary hospitals, and that they had more negative views when feeling overworked or had a preference for clinical tasks over labor support (Roth et al., 2016). They also found that doulas had more positive views of nurses when they were certified and worked
primarily in a hospital (Roth et al., 2016). Nurses who had positive attitudes towards common obstetric practices had more negative attitudes towards doulas (Roth et al., 2016). However, doulas that also had positive attitudes toward common obstetric practices had more positive, not negative, attitudes towards nurses (Roth et al., 2016). The authors concluded that familiarity and experience with each other’s roles may explain the findings. In addition, the factors that influence their view towards each other can be influenced by educational efforts, which could improve the interprofessional collaboration between the two roles (Roth et al., 2016).

**Summary and Limitations**

This chapter consisted of a literature review of contemporary research on the current relationship between doulas and healthcare professionals in the birth setting. There were a few themes that were seen across the literature: the broken maternity system, doulas overstepping the boundaries as advocates, doulas’ presence changing the relationship between the care provider and the woman, and doulas perceived as helpful support and facilitators. Most of the articles presented were qualitative research of doula-birth professional relationships. Each study differed in objective, inclusion and exclusion criteria, population, methods, and results.

Limitations of these studies included small sample sizes, lack of prior research on the topic, and self-reported data from the qualitative nature of the studies. Several studies included result from countries other than the United States, including Australia, Sweden, and Canada. Although these studies took place in settings outside of the U.S., the findings are applicable and relevant to U.S. hospitals since these are first world countries in which the majority of births take place in a hospital setting.
Conclusion

Research shows that although doulas are mostly perceived as valuable members of the birth team, the relationship between them and birth healthcare professionals is sometimes strained. This is mostly caused by healthcare professionals’ perceptions that the doula is overstepping boundaries, changing the relationship between the client and the provider, or taking from their roles. However, the effort for collaboration between doulas and healthcare professionals in the birth setting exists. Chapter 3 will present a protocol for enhancing this collaboration in order to provide the best maternal and newborn outcomes.
CHAPTER 3
RECOMMENDATIONS FOR ENHANCED COLLABORATION BETWEEN BIRTH DOULAS AND HEALTHCARE PROFESSIONALS

This thesis aims to provide best practice recommendations for enhancing the collaboration between doulas and healthcare professionals in the birth setting. The previous chapters focused on background information related to the role of the birth doula and the relationship between doulas and professionals. In addition, findings from the second chapter offered suggestions to overcome the strained relationships between the roles. This chapter presents the proposed recommendations for enhancing the collaboration between birth doulas and professionals.

Target Population

Interventions to enhance the collaboration of doulas and healthcare professionals in the birth setting will be applied to registered nurses, midwives, obstetricians, and doulas. The target population for this intervention includes: registered nurses working in an antepartum or labor and delivery setting including hospitals and birth centers; certified professional midwives, certified nurse midwives, and certified midwives working in a hospital or birth center; and physicians, including medical residents, working in a birth setting. The target population for doulas includes doulas certified by professionally recognized organization such as DONA, CAPPA, ICEA, ALACE, and any other professional organizations that certify labor and birth doulas. All doulas and healthcare professionals who satisfy the aforementioned criteria will be eligible for the interventions regardless of the years of experience in their field, their experience in collaboration with the other role, gender, race, or views on the role of the doula.
Interventions

The literature in Chapter 2 indicated overlapping themes such as: the broken maternity system that takes away from the role of the nurse and midwife, the problem with doulas overstepping the boundaries as non-medical advocates, doulas’ presence altering the relationship between the care provider and the laboring woman, and doulas being perceived as helpful support and facilitators in the birth setting. The literature also indicated that when doulas and nurses were more acquainted with each other’s role and the importance of the other role, they had more positive attitudes towards each other. Therefore, recommendations based on the literature findings will focus on educating birth doulas and labor and delivery professionals about the role of the doula and the importance of the doula in maternal healthcare. The recommendation will also include tips on how to establish rapport with other professionals.

Prior to implementing any recommendations, an interdisciplinary collaborative committee will be formed. This collaborative committee will teach and model the recommendations to the target population. The goal is to have at least ten individuals and for the committee to have at least one nurse, one midwife, one doctor, and one doula. The healthcare providers in the hospital labor and delivery unit will all receive an invitation to partake in the formation of this committee. In addition, the invitation will be extended to doulas in the community.

After the formation of this committee, the healthcare professionals will receive information through an in-service training put together by the committee. The training will be facilitated by an assigned professional from the collaborative committee who will use a PowerPoint presentation to convey the information from Table 1. In addition to the presentation, the healthcare professionals who attend the meeting will also partake in interactive learning
including a small-group discussion about working with doulas. By the end of the training, the healthcare professionals should be familiar with the role of the doula and the doula scope of practice. The healthcare professionals should be able to verbalize understanding about the importance of the doula in the birth setting, as well as the importance of excellent collaboration with them. The goal for this training is to acquaint the healthcare professionals with the doula’s role and importance in hopes of encouraging more positive attitudes towards each other.

The information given to healthcare professionals will also be in the form of a pamphlet (see Appendix A) created by the collaborative committee, as this is a concise document that can be easily stored and carried for future reference. The pamphlet will include the following sections:

- What is a doula?
- What is the role of a doula?
- Evidence-based benefits of a doula
- The importance of successful collaboration
- Our commitment to collaboration

In addition to educating healthcare professionals about the value of collaboration with doulas, the author plans to promote a clinical environment that is inclusive of doulas. This will be achieved through posters that will be placed throughout the birth unit (see Figure 1), which promote collaboration between doulas and birth professionals. The poster conveys a positive message that all birth professionals, doulas, and patients can see. The message of collaboration between doulas and healthcare professionals will shine a positive light on doulas and remind both patients and healthcare professionals of their value in maternal care.
Summary

Recent literature on the relationship between doulas and healthcare professionals shows that collaboration between the two roles is hindered by misunderstanding about the doula role from both sides, as well as the lack of good communication between the doulas and birth professionals. Therefore, the recommendation for increased collaboration is to define the role of the doula and to offer tips on successful professional collaborations between the two roles. This chapter introduced a method of transmitting the recommended information to healthcare professionals in the form of an in-service training, an educational pamphlet, and posters. Chapter 4 will discuss the plan for implementation of this intervention.
CHAPTER 4
IMPLEMENTATION AND EVALUATION

This chapter discusses the hypothetical implementation of recommendations for enhancing the collaboration between doulas and healthcare professionals in a Tucson hospital. In order to enhance collaboration, it is important to establish provider and doula acceptance of the proposed recommendations. In order to facilitate diffusion of new attitudes and ideas in the birth setting, the Theory of Diffusion of Innovation by Everett M. Rogers will be used (2003). Roger’s theory consists of a five-stage process through which individuals or groups of individuals decide whether to accept or reject and innovation (Rogers, 2003). This chapter will discuss the five stages: knowledge, persuasion, decision, implementation, and confirmation (Rogers, 2003). Roger’s theory will provide a framework for establishing acceptance of the proposed recommendations in the birth setting.

Prior to Implementation

Knowledge is the first stage of Roger’s Theory of Diffusion of Innovations (2003). During this stage, individuals are first exposed to, but lack information about, an innovation. In addition, they are not yet inspired to learn more about the innovation (Rogers, 2003). The healthcare professionals are exposed to the idea of enhancing the collaboration between them and doulas, but are not yet inspired to learn more about how to collaborate with them. During this stage it is necessary to assess the knowledge that healthcare professionals have about doulas and the attitudes that they have towards collaborating with them. In order to assess their level of knowledge and attitudes, the healthcare professionals will complete a brief survey prior to implementation of the recommendations. The survey will be administered by the assigned
professional from the collaborative committee who will facilitate the in-service training discussed in the previous chapter. It will include the following statements:

- I am familiar with the role and responsibilities of a doula.
- Doulas are important and beneficial members of the birth team.
- I enjoy working with doulas.

Each statement will be scored through a five-level Likert scale, which will capture the intensity of the participants’ feeling towards each statement. After the surveys are completed, the responses from each statement will be separated by answer. These responses will allow the in-service facilitator to get a sense of the healthcare professionals’ views and attitudes towards doulas.

In the second stage, persuasion, the individuals become interested in the innovation and actively seek information about it (Rogers, 2003). During this stage, each individual will form an attitude towards the recommendations after learning about them (Rogers, 2003). After learning about the proposed recommendations, the healthcare professionals and doulas will anticipate how the recommendations will have an impact on patient care and outcomes. Based on this, they will develop favorable or unfavorable attitudes towards the innovation (Rogers, 2003). It is preferable that they anticipate that enhanced collaboration will have a positive effect on their patients, as this may lead them to develop favorable attitudes towards the recommendations.

During the decision stage, the healthcare professionals and doulas will individually choose to either adopt or reject the change (Rogers, 2003). They will recognize the need for the change and accept the knowledge acquisition; or they will resist the proposed change in the future stages (Rogers, 2003). The healthcare professionals and doulas will attend the in-service, receive the pamphlet, and see the poster around the birth setting. Here the individuals will weigh
the advantages and disadvantages of using the knowledge and recommendations from the training and pamphlet and decide whether to accept or adopt it. It is important to note that ‘rejection’ means to not adopt the innovation. Therefore, if individuals decide against adopting the recommendations or do not think about adopting them at all, this is rejection (Rogers, 2003).

**Implementation**

The fourth stage, implementation, is when the individuals employ the innovation to varying degrees (Rogers, 2003). During this stage, the healthcare professionals and doulas will transition from hypothetical mental practice to behavioral changes using their new knowledge. They will choose to employ the recommendations from the in-service in order to improve their collaboration and create a better work environment. The change that results from the implemented recommendations may bring some degree of uncertainty about the diffusion of the innovation, which may lead to problems (Rogers, 2003). In the final stage, confirmation, the decision to adopt the change has been made but the individuals are looking to support their decision (Rogers, 2003). The healthcare professionals and doulas will finalize their decision to continue with their changed behavior if there is confirmation that they have made the right decision. Therefore, the group will seek supportive messages and attitudes about the enhanced collaboration with doulas. If during this stage negative feelings about collaborating with doulas develop, the group may still make the decision to reject the recommendations for enhanced collaborations.

**Evaluation**

Because the recommendations aim to enhance the collaboration between doulas and healthcare professionals, the evaluation of the proposed recommendations will focus on the quality of the collaboration between the roles after the diffusion of innovations. A short
questionnaire will be administered to healthcare professionals one month, three months, and six months after the in-service takes place. The questionnaire will include ‘yes’ or ‘no’ type questions as well as free response questions. This will generate both quantitative and qualitative data. The questions are the following:

- Do you feel as though you received enough training to understand the role and responsibilities of the doula?
- What would you like to learn more about in regards to doulas or working with doulas?
- Over the last month/three months/six months, have you employed any of the recommendation from the in-service to improve your relationship with doulas?
- What are the recommendations that you have used?
- Over the last month/three months/six months, do you feel as though your collaboration or professional relationship with doulas has improved?
- How has your professional relationship with doulas changed?

For the ‘yes’ or ‘no’ questions, the ‘yes’ answers will be awarded two points and the ‘no answers will be awarded no points. All of the scores will be added and then divided amongst the number of staff that completed them. The goal is to have a mean score of at least 4 points per person, which means that each healthcare provider will, on average, have answered yes to at least two of these types of questions. In addition, answers from the free-response questions will provide qualitative information. This questionnaire will give insight as to whether or not the recommendations were implemented by the staff and whether or not they were helpful in enhancing interprofessional collaboration between doulas and healthcare professionals.

In addition to this questionnaire, the collaborative committee will look at methods to assess the patient response to the collaboration between their doulas and providers.
Summary

The purpose of this thesis was to propose a best practice plan for enhanced collaboration between birth doulas and labor and delivery nurses and providers. The results of systematic reviews involving studies on continuous labor support have consistently shown that doulas are beneficial in the labor and birth process. Several studies suggest that problematic relationships between doulas and healthcare professionals may be due to misunderstanding about the role of the doula or miscommunication between the roles. Therefore, the recommendations based on the literature findings focused on educating doulas and healthcare professionals about the role of the doula and the importance of the doula in maternal healthcare. In addition, it included tips on how to establish rapport with other professionals. Everett M. Rogers’ (2003) Theory of Diffusion of Innovations was used as the framework to outline the implementation of these recommendations is a Tucson hospital birth setting. The effectiveness of the recommended interventions can be evaluated through a short questionnaire completed by healthcare professionals in the birth setting.
References


Klein, M. C., Kaczorowski, J., Hall, W. A., Fraser, W., Liston, R. M., Eftekhar, S., ... & Baradaran, N. (2009). The attitudes of Canadian maternity care practitioners towards...


### Table 1

**Recommendations for Educating Healthcare Professionals about Birth Doulas**

<table>
<thead>
<tr>
<th>Content of Training</th>
<th>Topics</th>
<th>References</th>
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| The Role and Responsibility of the Birth | - Doulas do not only provide care for women interested in natural births. They also support women who want childbirth with medication, who have little support, who are unaccompanied teen mothers, who have planned or unplanned cesarean sections, or who are attempting vaginal birth after cesarean.  
- Doulas stay with the woman throughout the labor, birth, and immediate postpartum period.  
- Doulas assist the woman in exploring, preparing for, and carrying out her plans for birth.  
- Doulas are trained to offer non-biased physical, emotional, and informational support for laboring women.  
- Physical Support*: The doula will offer position ideas to make the laboring woman more comfortable and help labor progress. They may remind the mother to maintain her fluid intake, make sure she uses the bathroom frequently, or offer the use of cold/heat therapy for pain relief. The doula will also provide non-medical comfort techniques like comforting touch, breathing techniques, visualization, music, and counter pressure.  
- Emotional Support: Doulas ease the emotional experience of birth, create an environment where the laboring woman feels comfortable, and help families feel supported. Birth doulas provide support to romantic partners, friends, or family members that are involved in the woman’s birth. They allow birth partners to participate at his or her comfort level. | CAPPA. (2015). Certified Labor Doula (CLD). Retrieved from http://www.cappa.net/labor-doula  
- Informational Support:
  Doulas are trained to help their clients connect with evidence-based resources that will allow them to make informed decisions about their births. Doulas provide information on birth options and resources.
- Doulas act as a bridge of communication between the laboring woman and clinical providers.
- Doulas help women find their voices and advocate for the very best care while maintaining an objective viewpoint.
- Doulas support and assist initial breastfeeding. They answer general questions about newborn care and breastfeeding.

Clinical Limitations of the Doula Scope of Practice

- Doulas do not act as midwives or midwives assistants, as an alternative medicine provider, or as a medical care provider.
- Doulas do not make medical decisions for the birthing woman.
- Doulas do not contradict health care providers or direct their clients to act against medical advice.
- Doulas may not perform clinical or medical tasks such as taking vitals, checking fetal heart tones, or performing vaginal examinations.
- Birth doulas cannot: diagnose medical conditions; interpret medical diagnoses; interpret clinical results; prescribe medical treatments; administer medical treatments; speak for the birthing woman; transport family members; or prescribe, perform, or provide alternative or complimentary therapies (essential oils, placenta medicine, herbal treatments, etc.).
- Doulas who are trained or licensed in alternative or complimentary therapy must present those services as separate from their doula role.
- Doulas who are also healthcare professionals, such as a nurse or midwife, may not refer to him/herself as a doula if providing services outside of a doula scope of practice. However, a healthcare


provider who chooses to limit his or her services to the doula scope of practice may describe him/herself as a doula.

**The Evidence-Based Benefits of Birth Doulas in Maternity & Newborn Care**

- Women who have continuous labor support:
  - are more likely to give birth spontaneously
  - are less likely to require surgical or instrumental interventions including vacuums, forceps, or cesareans
  - are less likely to use pain medications including epidurals
  - are more satisfied with their overall birth experience
  - have shorter labors
  - give birth to newborns that are less likely to have low five-minute Apgar scores
  - have significantly higher rates of breastfeeding and early initiation of breastfeeding

- There is a cost benefit to having a doula.
- There are no adverse effects found in having continuous labor support.


**Cause of Conflicts and the Importance of Good Collaboration**

- The role of the doula is still not widely embraced in the hospital setting due to misunderstanding about the doula role, as well as negative interactions between doulas and birth professionals.
- The doula may often be perceived as an unfamiliar role in the care team.
- The doula and birth professional may mistrust each other.
- Doulas and healthcare professionals should respect each other’s


Ballen, L. E., & Fulcher, A. J. (2006). Nurses and doulas: Complementary roles to provide
role and work as a team to provide the best care.
- Conflict between doulas and healthcare professionals may have detrimental effects on the laboring woman and the fetus. It may undermine her confidence in the care team, cause tension or anxiety, and affect the emotional and physical well-being of both the mother and fetus.


Tips on How to Create a Harmonious Work Environment
- Remember to place the patient's interest first.
- Introduce yourself professionally to other members of the care team.
- Communicate your role and responsibilities clearly to other professionals.
- Understand the role and responsibilities of other professionals.
- Respect the role, responsibilities, and expertise of other professions.
- Maintain competence in your own profession appropriate to scope of practice.
- Engage in continuous professional behavior.
- Explain your knowledge and opinions to other team members with clarity and respect to ensure common understanding of care.
- Listen actively to the ideas and opinions of other team members.
- Use respectful language during difficult situations, disagreements, or conflict.
- Communicate disagreement to other professionals in a clear, respectful manner.


* The doula will work with the nurse to identify appropriate support measures that can be offered to the patient. The doula will not offer measures that are contraindicated by physician orders.
midwives  doulas  nurses  doctors

working together to bring you the best birth experience

we care.
Appendix A

**OUR COMMITMENT TO COLLABORATION**

- The patient’s interests come first
- Introduce yourself professionally to other members of the care team
- Communicate your role and responsibilities clearly to other professionals
- Understand the role and responsibilities of other professionals
- Respect the role, responsibilities, and expertise of other professionals
- Maintain competence in your own profession appropriate to scope of practice
- Engage in continuous professional behavior
- Explain your knowledge and opinions to other team members with clarity and respect to ensure common understanding of care
- Listen actively to the ideas and opinions of other team members
- Use respectful language during difficult situations, disagreements, or conflict
- Communicate disagreement to other professionals in a clear, respectful manner (Interprofessional Education Collaborative Expert Panel, 2011)

**REFERENCES**


**Birth Doulas & Professionals: Strength in the Maternal Care Team**

Information for creating successful professional relationships

Created by the Collaborative Committee of Doulas and Healthcare Professionals
WHAT IS A DOULA?

The word 'Doula' is an ancient Greek derived term for a "woman who serves", and is now used to refer to trained professionals who provide continuous non-medical physical, informational, and emotional support to women before, during, and after birth (DONA International, 2005a).

WHAT IS THE ROLE OF THE DOULA?

A birth doula:

- recognizes birth as a key experience the mother will remember all her life
- understands the physiology of birth and the emotional needs of a woman in labor
- assists the woman in preparing for and carrying out her plans for birth
- stays with the woman throughout labor
- provides emotional support, physical comfort measures and an objective viewpoint, as well as helping the woman get the information she needs to make informed decisions
- facilitates communication between the laboring woman, her partner, and her clinical providers
- perceives her role as nurturing and protecting the woman's memory of the birth experience
- allows the woman's partner to participate at his/her comfort level (DONA International, 2005a).

EVIDENCE-BASED BENEFITS OF A DOULA

Women who have continuous labor support:

- are more likely to give birth spontaneously
- are less likely to require surgical or instrumental interventions including vacuum, forceps, or cesareans
- are less likely to use pain medications including epidurals
- are more satisfied with their overall birth experience
- have shorter labors (Hodnett et al., 2013)
- give birth to newborns that are less likely to have low five-minute Apgar scores (Hodnett et al., 2013).
- have significantly higher rates of breastfeeding and early initiation of breastfeeding (Kozhimannil et al., 2013).

Research shows parents who receive labor support:

- feel more secure and cared for
- have greater success with breastfeeding
- have greater self-confidence
- have less postpartum depression
- have lower incidence of abuse (DONA International, 2005b)

THE IMPORTANCE OF SUCCESSFUL COLLABORATION

It is essential that doulas and birth professionals respect each other's roles and work together as a team to provide the best care for childbearing women and their families. Conflict between the two is not only undesirable, but may also have detrimental effects on the mother, such as tension or anxiety that can negatively affect the woman and fetus (Pepagni & Suckow, 2005).