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"A Doula Can Only Do So Much": Birth Doulas and Stratification in United States Maternity Care

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“A Doula Can Only Do So Much”: Birth Doulas and Stratification in
United States Maternity Care

An Honors Paper for the Department of Sociology and Anthropology

By Kaylee Shae Wolfe

Bowdoin College, 2015

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This thesis is dedicated to my little sister, Evangeline Guzik, whose curiosity, intelligence, kindness, and sense of humor inspires and motivates me every day.

1. Introduction

A birth doula is a skilled labor companion who provides continuous emotional, physical, and informational support to women before, during, and immediately after birth. Birth doulas offer a range of services and support complementary to the care provided by physicians, midwives, and nursing staff. While medical care providers monitor the condition of mother and baby, track the progress of labor, perform interventions as necessary, and manage delivery, doulas attend to the mother's non-medical needs. Doulas' emphasis on non-medical tasks is what sets them apart from the midwives, physicians, and nurses that conventionally attend to labor and childbirth within the hospital setting, and the standards of practice set forth by mainstream certifying organizations explicitly forbids their involvement in such types of care. Instead, they suggest non-pharmacological methods of pain relief, give encouragement, provide physical comfort through soothing touch and massage, and facilitate communication between women and their care providers, among other related tasks.

Birth doulas currently practice throughout all 50 states and the District of Columbia, and DONA International¹, America's longest-standing doula certifying organization, also boasts having members in 50 other countries (DONA International 2014). While birth doulas are present in other countries, they are most prevalent in the United States, which is the regional focus of this work. Figuring out the exact number of doulas currently practicing, however, is difficult. There are a number of certifying organizations from which a would-be doula may choose to receive her training, and not all of them report their membership statistics. Furthermore, even if consistent data from

¹ DONA originally stood for "Doula of North America," but this acronym was abandoned when the organization took on a more international scope. DONA no longer technically stands for

certifying organizations were available, there is the potential for a significant discrepancy between the number of individuals who complete a training program and the number of individuals who subsequently either never practice professionally, or choose to go into practice without completing the remaining steps in the certification process. Since doula care is not formally regulated by any federal or state laws that would create an easy way to register and count them, their prevalence and impact is difficult to quantify.

Still, it is possible to gain some clues about the number and geographic distribution of birth doulas in the United States. DONA International, which claims to be the largest doula certifying organization in the U.S., has certified 10,000 total birth and postpartum doulas since it was first established in 1992.² Currently, they have 6,500 active, dues-paying certified members (DONA International 2014). Unfortunately, these numbers still fail to capture doulas certified through alternative organizations and doulas who opt out of formal certification entirely, and also fail to provide any sense of where in the country doulas are most concentrated or rare. DoulaMatch.Net is an online service unaffiliated with any particular certifying body, and its membership is not limited to doulas with formal credentials. Self-identified doulas seeking clients can set up a profile with their training, experience, skills, and availability so that individuals interested in hiring a birth doula can browse their information. As Table 1.1 shows, a total of 6,792 doulas were registered on DoulaMatch.Net as of April 2015. Doulas are often, but not always, more prevalent in states with higher populations; however, the overall ratio of doulas relative to the general population is extremely low across the board. It is important

² Postpartum doulas provide emotional support and help with baby care and household tasks for new mothers and their families during the days and weeks after birth. Since DONA's postpartum certifying program is fairly new, the vast majority of their 10,000 total members over time is likely made up of birth doulas.

to keep in mind that these numbers are not a perfect representation of the U.S. doula population. In Maine, for example, only 64 doulas are registered on DoulaMatch.Net, but well over 100 self-identified doulas are currently listed as members in a Facebook community for birth doulas in the greater Portland area alone. Still, taking a look at these state-by-state data can provide an imperfect but perhaps insightful glimpse at where in the US practicing birth doulas, both certified and uncertified, are found and in approximately what numbers.

Table 1.1: Number of Birth Doulas by State According to DoulaMatch.Net			
State	# of Doulas	State	# of Doulas
Alabama	58	Montana	24
Alaska	30	Nebraska	51
Arizona	170	Nevada	39
Arkansas	39	New Hampshire	48
California	784	New Jersey	147
Colorado	170	New Mexico	22
Connecticut	65	New York	390
Delaware	23	North Carolina	175
Florida	309	North Dakota	18
Georgia	181	Ohio	152
Hawaii	20	Oklahoma	86
Idaho	83	Oregon	184
Illinois	282	Pennsylvania	176
Indiana	136	Rhode Island	17
Iowa	96	South Carolina	58
Kansas	65	South Dakota	18
Kentucky	50	Tennessee	105
Louisiana	64	Texas	373
Maine	64	Utah	98
Maryland	172	Vermont	30
Massachusetts	204	Virginia	294
Michigan	137	Washington	562
Minnesota	224	West Virginia	14
Mississippi	29	Wisconsin	95
Missouri	110	Wyoming	18

Total Doulas: 6,792

Source: DoulaMatch.Net

Numerous studies on the impact of doula care suggest that their involvement in a given birth can reduce the rate of interventions including the use of pain medicine, forceps, and cesarean section, have positive effects on maternal-infant bonding and postpartum health indicators for both mother and baby, and improve mothers' overall level of satisfaction with their birthing experiences (Sosa et al. 1980; Klaus, Kennell, and Klaus 1993; Hodnett et al. 2012; Kozhimannil et al. 2013; and others). But in spite of the apparent benefits of doula care and growing media coverage—including a recent front-page feature on doula care in *The New York Times*—their presence in the labor room remains infrequent. According to *Listening to Mothers III*, a 2012 nationwide survey of 2,400 American women who had given birth to single children in a hospital setting at some point during the prior year, only 6% of women received supportive care from a doula (Declercq, Sakala, Corry, Applebaum, and Herrlich 2013:13). Interestingly, the small overall proportion of births attended by doulas does not appear to be for lack of awareness. *Listening to Mothers III* also found that 75% of women who did not have a doula present at their birth had heard of doulas before, and of that group 27% reported that they would have liked to have had a doula. These statistics indicate a significant gap between the desire for doula care and the number of laboring women who actually end up receiving it during their birth experiences.

Why Study Doulas?

The provision of social and emotional support during labor has not always been considered a profession; in fact, it is a fairly recent phenomenon which emerged out of the childbirth education movement of the 1960s and 70s. The first professional

organization for doulas, called the National Association of Childbirth Assistants (NACA), was founded in 1984 by childbirth educator Claudia Lowe (Morton and Clift 2014). When NACA dissolved in 1994, several other organizations had already begun to offer training and certification programs of their own. The longest-running doula training and certification organization currently in existence is only 23 years old—an incredibly short period compared to the total history of pregnancy, childbirth, and labor support in the United States.

Given the relative novelty of birth doulas within the American maternity care system, a number of questions become apparent. Why doulas, and why now? Are they filling a new need, or are they a modern response to an existing need or problem? How do they operate within and impact the wider maternity care system? Who are they serving, and, conversely, who are they not serving? Is it possible to professionalize and commodify the exchange of social and emotional support between human beings, which is their primary stated purpose? While a fair amount of research evaluating the effectiveness of doula care on maternal and infant health outcomes has been completed over the last few decades, very little scholarship has sought to examine the work and role of doulas themselves.³

The role of doulas within the American maternity care system is a truly unique one. Most care provided by doulas takes place within a hospital setting, yet they are almost never hospital employees or volunteers; instead, they are contracted directly by the women and families to whom they provide their services. As practitioners of a form of complementary medicine who frequently carry out their work in the highly

³ A recent exception to this trend is *Birth Ambassadors: Doulas and the Re-Emergence of Woman-Supported Birth in America* by Christine Morton and Elayne G. Clift (Praeclarus Press, 2014).

medicalized setting of hospital labor wards, doulas stand at an interesting intersection between the institution of medicine, with its technocratic orientation toward birth, and a more holistic, woman-centered, and empowerment-focused approach to the process. Although much has been said and written about the potential for doulas and medical personnel to work together for better maternity outcomes (Ballen 2006; Kayne, Greulich, and Albers 2001; Gilliland 2002), this project seeks in part to learn more about what these interactions and partnerships are like in the lived experiences of doulas who practice in hospital settings as simultaneous “outsiders” and “insiders”—outsiders within the hospital setting, but insiders to the needs and desires of the individual women they are there to serve.

Another interesting aspect of birth doula care relates to issues of professionalization. Doulas are professionals insofar as they are typically trained and experienced in providing skilled emotional, physical, and informational support to pregnant and laboring women; however, they are not regulated by any formal laws or standards. Often loosely organized with fellow doulas in the local area or online, doulas may or may not choose to go through the process of certifying with one of the many doula training organizations which exist in the United States. Doulas are almost always self-employed and contracted directly by the women they serve, meaning that they are independent of any institutional affiliation. While virtually all professional doulas offer a core set of key services and skills, individual values, styles of practice, and approaches to the role of a doula in a hospital context vary widely within the doula community, and there are a number of intense debates about the nature and future of doula care currently carrying on both in local doula communities and larger online forums. Some see offering

pro-bono services to disadvantaged clients as critically important to achieving social justice in maternity care, while others argue that giving doula support for free devalues the entire profession and only accept paying clients. Some believe that doulas should be vocal advocates for their clients even if it means directly confronting medical expertise, while others prefer to support their clients in making decisions but stay out of interactions with hospital staff. Some favor a centralized model of national certification, while still others argue that such a model would be an intolerable compromise on their professional autonomy.

In spite of their decentralized organization, unregulated status, and the significant disagreements that currently exist between various “camps” of opinion within the doula community, certifying organizations and individual birth doulas assert their status as members and representatives of a true profession. But what does it mean to “create” a profession within the highly specialized healthcare field, especially when the role of that professional is explicitly supposed to be “non-medical” in nature? At what point does a type of work or person become “professional”? And what purpose does claiming status as a professional serve for individuals in the doula care field? These questions don’t just apply to doulas, but to other types of caregivers and practitioners of complementary and alternative medicine as well. Healthcare—and especially the “caring” parts of healthcare—are rapidly evolving areas in American society. Understanding the role of doulas as “professionals” simultaneously marginal to and present within the healthcare system could shed light on the role of other providers of complementary and alternative health services, support, and care. And furthermore, since doulas (and many other complementary and alternative medicine providers) are not covered by insurance or

public assistance programs, access to their services is often stratified along socioeconomic lines. Taking a closer look at their role and impact within the maternity care system may provide an opportunity to better understand how the wider American healthcare system operates to provide, facilitate, or withhold certain types of care for certain groups.

What began for me as a project exploring the experiences of birth doulas in hospitals in Southern Maine has evolved over time into an investigation of the complex and contradictory ways in which doulas simultaneously resist and support the institution of medicalized birth as it currently exists in the United States. While the benefits of their services for the individual women that birth doulas serve are significant and well-supported in existing clinical research, less is known about their impact on the wider maternity and healthcare system in which they operate. Because of the relative specificity of populations most likely to not only know what a doula is, but also seek one out and have the ability to pay out-of-pocket for her services, it is likely that the benefits of doula care are disproportionately concentrated among women of relative privilege—but that doesn't mean that poor women, rural women, and women of color without doulas remain unaffected by their presence in maternity care. On the contrary, I argue that there exists a possibility for doulas to impede systematic improvements to American maternity care even as they simultaneously challenge its conventionally technocratic, medicalized approach to birth in the labor rooms of their clients. By improving the birth experiences of women who can afford their services, doulas may be effectively “de-radicalizing” their privileged clients, making those with the voices most likely to be heard by the healthcare

establishment less motivated to rally for reforms that would impact pregnant women across spectra of race and class.

Following a description of my methodological approach to gathering and analyzing data gained through qualitative interviews with five birth doulas who currently practice in hospital settings, I continue into a literature review which examines the history of social and emotional support during childbirth in the United States from the colonial era to the present. Next, a chapter exploring themes and insights gained from interviews with actively practicing doulas provides an overview of their experiences navigating hospital settings as a relative outsider and interacting with hospital staff as a third-party provider of an alternative model of intrapartum care, alongside critical analysis of doulas' work and potential impact within the wider context of the maternity care system. Finally, a concluding chapter explores the benefits that doulas offer their clients and the hospitals in which they work, as well as the challenges faced by the profession, including the potential to inadvertently contribute to stratification within maternity care and the possible consequences of commodifying the nurturing and emotional labor that is central to the doula profession.

2. Research Methodology

During the fall and winter of 2014-2015 I conducted expert interviews with practicing birth doulas throughout southern Maine. Research subjects were recruited through a large and active Facebook group called Doulas of Northern New England⁴ whose membership is open to birth doulas and other non-medical birth workers (e.g. lactation consultants, placenta encapsulators, postpartum doulas, childbirth educators) practicing in the region. Being a birth doula myself made it possible for me to gain access to the group and its members, who currently number more than 100. Participation in this community is frequent and enthusiastic, both on- and offline. Individual members regularly organize book discussion groups, potlucks, and afternoon teas to which everyone else is invited via specially created Facebook event pages. Research articles about the doula profession and the field of birth more generally are frequently posted, shared, and discussed by members, demonstrating a common interest in the search for more knowledge about their work and its many dimensions. Given the high level of activity within the group and the clear general interest in research among members, Doulas of Northern New England seemed to be an ideal place to seek research participants.

After my project received approval from Bowdoin College's Institutional Review Board, interviewees were solicited through a post made to all members of the group introducing myself as a researcher and describing my project. To be eligible for participation, potential research subjects had to be currently practicing as birth doulas at least partially in a hospital setting and over the age of 18. Consistent with the group's

⁴ The name of the group has been changed to protect the confidentiality of my respondents.

general interest in research about their profession, the response to my post was fairly quick and uniformly positive. One of the group’s leaders even went out of her way to post a comment reaffirming the importance of studies about doulas, then specifically “tagged” other members of the group she thought should participate to ensure that they would see the post (Figure 2.1). This endorsement proved to be rather useful, as multiple doulas mentioned in her comment actually did decide to contact me about setting up an interview.

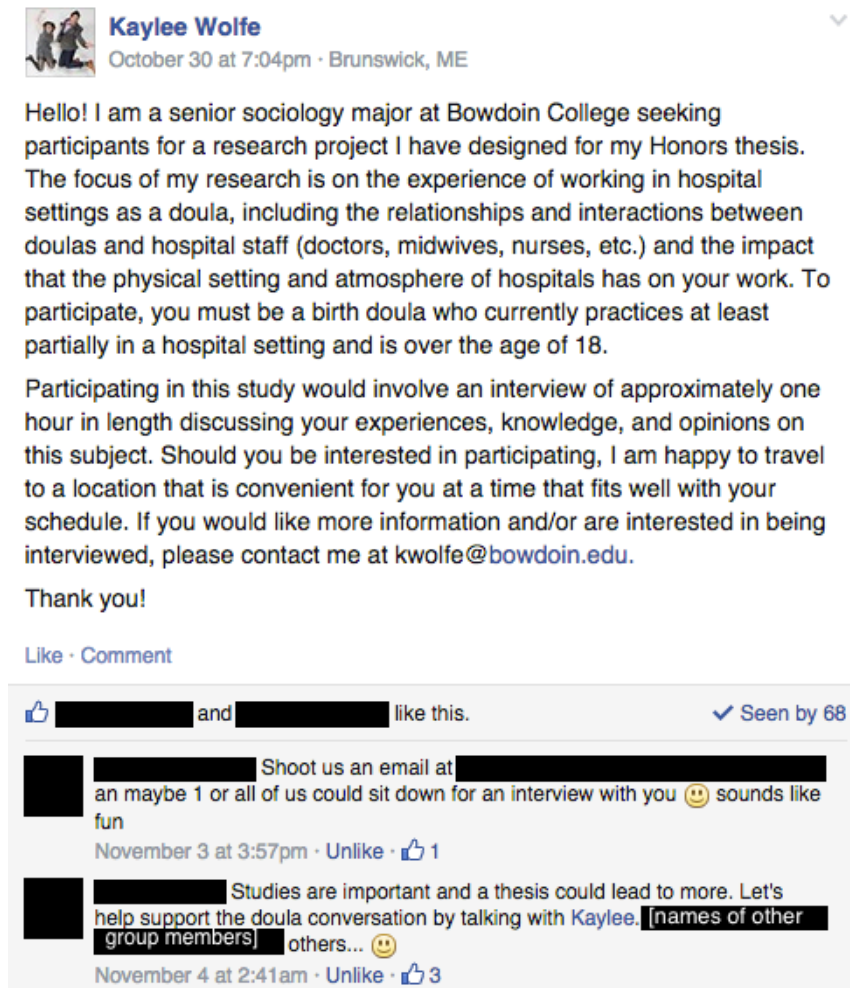


Figure 2.1. My original post to the Doulas of Northern New England Facebook group seeking research participants and a portion of the resulting comment thread. The second commenter, one of the group’s moderators and a frequent organizer of in-person events for doulas in the area, spontaneously supported my request by emphasizing the importance of research for the doula profession and “tagging” fellow doulas she thought might be interested.

After following up with those who expressed interest in participating in or learning more about the project, I was able to schedule a total of six interviews spread out between November 2014 and January 2015. Interviews were semi-structured and typically ran for about one hour in length. I did not follow a strict interview protocol; instead, interviews were modeled more like conversations with a loose agenda of topics, allowing for participants to help guide the conversation by sharing information about things they saw as important or relevant as we moved from topic to topic. Specific items covered in each interview included how the interviewee had come into the doula profession, their experiences working in hospital settings and with hospital staff, the rewards and challenges of their work, the characteristics of their client population, the services they offered to their clients, and their thoughts on the future of doula work, both for themselves and for the profession as a whole. Each interview was recorded using a digital voice recorder iPad application.

All five of the doulas I interviewed identified as white women. Three had had children of their own, while two had never given birth themselves. They ranged in age from 26 to 55 years old. Most worked independently as doulas and were therefore self-employed, though one was a member of an established business collaborative with other doulas. Two pursued doula work as their primary occupation, while the remaining three had other full- or part-time work and family commitments to which their doula work offered a complementary income.

Interviews with each of these women were transcribed, printed, and then subjected to an extensive process of open coding. Identifying information was removed from each interview during the transcription process to protect the confidentiality of all

respondents. By reading and rereading the interviews highlighting key facts, insights, and experiences, a number of common themes present in all of the interviews became apparent. These themes gave rise to a shorter list of topics which evolved into the major sections of the data chapter contained later in this work. To fully understand and provide context for the experiences each doula shared, existing literature from scholarly, professional, and popular sources both in print and online were frequently consulted for context and aid in analysis.

Navigating Relationships with Interviewees

My interest in this topic as a researcher emerged from my own training and experiences as a birth doula. In August of 2013, I was present for the birth of a close relative's first son. Although I had had virtually no experience with pregnancy and childbirth before that moment, I suddenly found myself providing impromptu support for my aunt as she soldiered valiantly through an almost 24-hour labor. The experience was like nothing I had ever known before, and quite literally overnight I fell in love with birth. In searching for ways to get back into the labor room and gain more experience with the process, I found out that a DONA International birth doula training was being offered near my home during a school break and eagerly signed up. In January 2014 I became a trained birth doula, and the following summer I assisted my first paying client through the birth of her third child.

Negotiating my personal role and experience as a doula while conducting interviews and developing a critical perspective on their work was not always easy. Either before or after each interview, all of my respondents asked questions about my

personal reasons for investigating their work. They were curious to know what I was studying at Bowdoin, if I was a doula or aspiring doula myself, and whether my career goals were related to the world of pregnancy and birth. Navigating these conversations was occasionally tricky, especially when questions arose before the interview began. Although I speculated that relating to my interviewees as a fellow doula might have helped to build rapport and opened certain conversational doors during the interview, I was concerned that it would conversely lead my interviewees to skip over information they thought of as basic, thereby altering the data I would be able to collect. I was also concerned that they would be interested in learning more about my own personal opinions related to the subjects at hand if they knew that I was also in the field or that they would become more reserved about expressing potentially controversial opinions, especially when it came to more contentious topics related to doula practice. Consequently, it seemed more advantageous to approach my interviewees as a relative outsider rather than making use of my position as a fellow birth worker.

When I encountered this dilemma in the very first interview I conducted, it was admittedly not something I had thought to account for in advance. I made a spontaneous decision to avoid talking about myself before the interview except in very general terms. I openly answered general questions about my hometown, year in school, and major, but attempted to dodge or redirect questions related to my personal involvement in the field of birth work and future goal of studying midwifery. After the interview when my interviewee repeated her questions about my motivation for being interested in this topic, I answered more freely. I maintained a similar strategy in all of my subsequent interviews, except in one case where my interviewee was particularly persistent in trying

to learn more about me before the interview began. In that case, sharing information that I would ordinarily have saved until after the interview seemed less disruptive to the process than continuing to deflect her inquiries.

My interviewees' interest in my personal story and relationship to their work as a researcher seems to reflect a general interest in storytelling and personal experience present in the doula community. Many doulas offer to write "birth stories," or a narrative account of their client's labor and birth experience, as a part of their services, actively marketing their ability to observe, participate, and document significant life events in the format of a personal story. When asked how they found themselves pursuing their current role as a doula, almost all of my respondents had a clear story to tell connecting different experiences, memories, and anecdotes into a journey that brought them to the work.

It is important to note that although I did my best to keep my own identity as a doula out of my interactions with respondents until the formal interview had concluded, it is impossible to truly know whether or not my insider status affected the interviews. Simply by being a member of the Facebook group where I reached out to potential interviewees could have been a sign to my respondents that I was in some way already a part of their community. A quick Google search of my name by anyone interested in learning more about me before agreeing to an interview would have returned a list of links including my personal Twitter page and blog, where my identity as a trained birth doula is fairly obvious, as well as an article from the Bowdoin Daily Sun specifically highlighting the birth-focused aspects of my work which was released partway through the interview stage of this project. Although none of the respondents in this study mentioned being aware of my background before we spoke, it is still entirely possible

that they were. Consequently, it cannot be ruled out that my status as a fellow birth doula did not influence the information my respondents shared with me and the way they chose to share it. This experience raises interesting questions regarding the influence of researcher identity in a world where more and more information about individuals is becoming gradually available online as people—researchers included—create and maintain online profiles and personas that potential research subjects can access.

Sharing Digital Space with Respondents

Being a member of the Doulas of Northern New England Facebook group along with my interviewees added a unique and unanticipated dimension to my research. As posts from the group regularly appeared in my own News Feed while I casually browsed the site, I was able to passively observe my interviewees' posts and interactions with other members of the group. This information added another layer to my understanding not only of my respondents' experiences as doulas, but also their relationship with the region's wider professional community. In one particularly striking example, having access to these public posts even provided insight into the effect that participating in a research interview for my project apparently had on one of my respondents.

During our interview, this respondent described a recent birth she had attended that was unusually difficult, both emotionally and physically. When I asked a follow-up question regarding self-care and how she processed and recharged after such experiences, she paused and was momentarily unsure of what to say. Eventually, she responded that she did not have a particular method for dealing with those kinds of experiences. She added reflectively that this was “probably not ideal,” but that she hadn't given it much

thought before. Later that day, I logged onto Facebook to see that she had posted to the group asking for other doulas' input on ways to “mentally recoup after an extremely trying birth” (Figure 2.2), and in the hours that followed other members commented with their own strategies and tips. Seeing that participating in an interview with me had had an apparent effect on this interviewee was both rewarding and insightful. That this particular doula turned to the group for advice reinforced the sense of mutual support apparent in interactions between individual members and the wider online community.

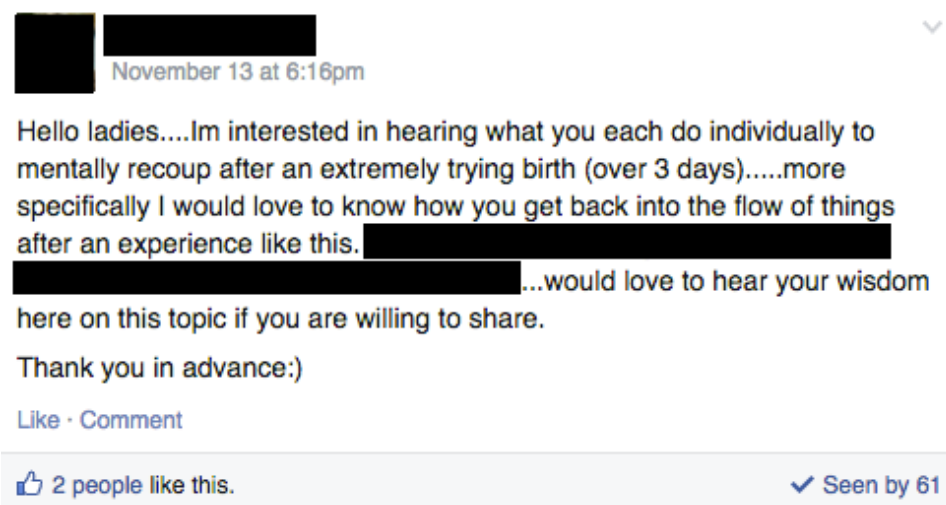


Figure 2.2. After participating in an interview for my project where the topic of self-care after attending a difficult birth arose, this interviewee consulted other members of the Doulas of Northern New England Facebook group for advice.

While sharing a digital space with my interviewees offered a unique window into the way they interacted with the wider doula community of the region, it also presented some dilemmas. In our increasingly interconnected world where “Being human is becoming more and more a matter of being online,” online interactions generate a wide range of ethical questions and methodological concerns for social science researchers to consider (Capurro and Pingel 2002:189). What, if any, information found outside the face-to-face interview setting may be included without the individual’s explicit

permission? How might being privy to a person's online presence bias or predispose an interviewer upon meeting that person in the real world? These and other questions merit serious consideration and debate, both in my project and in the field of research sociology more generally.

However, as Hannah Deakin and Kelly Wakefield have previously noted, "Debates surrounding online research ethics are 'work in progress', and the ethical challenges are not simple" (Deakin and Wakefield 2013:4). In the constantly developing field of communications technology, social science researchers must continually adapt and reassess their online activities within the context of their role as a researcher and the ethical responsibilities that accompany it. Among the existing body of literature regarding online social science research methodology, I was unable to find any articles specifically describing my unique situation of both formally interviewing my respondents as well as being informally connected to them through a shared space on social media.

On the one hand, information shared on social media sites and in other online communities is intended for the eyes of others—including, though perhaps not always intentionally, the eyes of social science researchers. As one pair of German scholars notes:

...users of social network sites normally do not only give their personal information to the site's owner; they post the information on the site, thus anyone can access it as it is publicly available on the social network site. To put it differently: They publish their data in order to make others read it, think about it, answer to it, etc. (Hoser and Nitschke 2010:184).

If the intention is for others to read and respond to content shared on a social networking site, are researchers seeking to analyze such information implicitly included in the

audience among all potential readers? In the same article, Hoser and Nitschke propose a rule that seems to indicate that the answer to this question is no:

Thus, we could establish a simple rule: The data someone posted, e.g. in a social network site or newsgroup may be used in the context and by the audience he or she intended it for. The intended audience is, even if it is large and not personally known to the user, the ‘community’ he or she joined. So nobody else should be allowed to use, without consent, the data generated in such a site. Researchers are probably not the audience an average user intends to reach by his or her postings and serving as a research object is normally not the purpose an average user has in mind when posting...(Hoser and Nitschke 2010:186).

Unfortunately, this ‘simple rule’ fails to anticipate the possibility of the very case in which I currently find myself—that I am simultaneously a researcher *and* a legitimate member of the online community which my interviewees are addressing. Under these circumstances, my position relative to my interviewees and the digital space we share seems more similar to participant observation than the online voyeurism implied by other forms of online research and data collection.

There appears to be no clear guide to follow when it comes to this issue, since the limited methodological literature on the subject is still developing and often contradictory. Turning to my own ethical reasoning, the use of data from this online community with all identifying information removed seems reasonable. For one, by Hoser and Nitschke’s own standards, I am truly a member of the posters’ target audience since they are sharing content intended for other doulas within the group, a category into which I legitimately fall. Also, all users within the group—and particularly those who responded to my requests for an interview and ended up participating in my research—have been made aware that I have access to what is shared publicly on the Doulas of

Northern New England page based on posts I have made identifying myself as a researcher.

Future work in research ethics and methodology would benefit from careful consideration of the constantly changing privacy options and settings within the online landscape so that situations like this might be less murky for future researchers. Semi-private groups of this nature—where all members have access to all content, but it is not visible to outsiders—are extremely common among groups of professionals and users sharing special interests on social networking sites such as Facebook. That no consensus yet exists on this subject is a gray area which merits discussion given the ever-evolving role and apparent increasing importance of online life in relation to the lived experiences of individuals, both at work and informally.

3. From Community Support to Professionalized Doula Care: A History of Intrapartum Social and Emotional Support in the United States

Across time periods and diverse cultures around the globe, social and emotional support for laboring women has often been recognized as having value during the process of parturition. Both skilled birth attendants and lay individuals—typically women—have participated in the process of supporting their friends, family members, or neighbors as they cross the threshold from pregnancy to motherhood. In her classic study of birth in the Yucatan Peninsula, for example, Brigitte Jordan describes the practices of indigenous people living in Guatemala. In the village where she conducted her fieldwork, local midwives trained through apprenticeship were considered central to the process of bringing babies safely into the world. But just as key were the female friends, family, and community members that came to surround the laboring woman throughout the process, serving in shifts throughout the day and night to ensure that she was never alone or without a steady stream of comfort, support, nourishment, and advice as she labored (Jordan 1978). In other cultures and historical moments, countless women have provided similar types of support to one another. Though they do not always have a title, their work and care closely resembles the type of services and support offered by modern birth doulas.

The provision of social and emotional support during childbirth is not merely of cultural significance. Repeated clinical trials and studies in a variety of contexts both in the United States and abroad have also shown that these types of support can yield significantly improved health outcomes for both mother and baby. The earliest Western medical pioneers in this field of research were Marshall Klaus and John Kennell, a pair of

pediatricians whose original interest was in maternal-infant bonding. In the course of their research on that topic, they stumbled upon a finding that surprised them: That the type of support mothers received during the process of parturition had an impact on the way they bonded with their infants (Gilliland 2002:763). With this discovery, the focus of their research began to shift. Intrigued by the concept of a “doula” as defined by anthropologist Dana Raphael, they wondered how the presence of a skilled, non-medical support person might influence the maternal-infant bonding process (Klaus, Kennell, and Klaus 2012:4). While Raphael’s work focused on women who assisted new mothers in the postpartum period by supporting breastfeeding efforts, providing advice and encouragement, and helping with other parenting and household tasks, Klaus and Kennell wondered what influence support *during* labor might have on bonding in the minutes and hours immediately postpartum (Raphael 1973).

This curiosity inspired a pilot study in a Guatemalan hospital examining the effects of continuous support during labor by a “supportive lay woman” unrelated to the patient on the health outcomes and maternal-infant bonding of primigravid women, or first-time mothers (Sosa, Kennell, Robertson, and Urrutia 1980:597). Borrowing Raphael’s term (which was itself a borrowed Greek word roughly translating to “woman servant”), the researchers called these supportive lay women *doulas*. To their surprise, the researchers observed that the benefits of labor support went beyond just improved bonding. Additionally, mothers in the experimental group experienced a statistically significant reduction in the average length of their labor, as well as lowered rates of complications and the use of medical interventions to augment contractions or assist with delivery such as synthetic hormones or the use of forceps. Klaus, Kennell, and colleagues

concluded that “[their] observations suggest[ed] that there may be major perinatal benefits of constant human support during labor,” and that “This low-cost intervention may be a simple way to reduce the length of labor and the number of perinatal problems for parturient women and their infants” (Sosa et al. 1980:597, 600).

A number of follow-up studies were conducted in both the United States and other countries to further investigate the effects of social support during labor (Steel et al. 2014; Hodnett et al. 2011; Kayne, Greulich, and Albers 2001; and others). Though the degree of these effects varies between trials, the vast majority of these studies confirm the original findings by Kennell, Klaus, and their colleagues: That the presence of continuous social support during labor significantly reduces the rate of medical interventions during childbirth and results in improved health outcomes for mother and baby. By 1993, enough evidence had accumulated to compel Klaus, Kennell, and co-author Phyllis Klaus⁵ to offer an explicit endorsement of doula care in their book, *Mothering the Mother: How a Doula Can Help You Have a Shorter, Easier, and Healthier Birth*.⁶ They wrote:

The presence of a doula reduces the overall cesarean rate by 50 percent, length of labor by 25 percent, oxytocin use by 40 percent, pain medication by 30 percent, and the need for forceps by 40 percent, and requests for epidurals by 60 percent (Klaus Kennell, and Klaus 1993:51).

This body of research has come to form the empirical foundation upon which the doula profession has asserted itself as effective and legitimate to both potential clients and the institution of medicine.

⁵ Phyllis Klaus a prominent psychotherapist whose specialty is the perinatal period. She is also Marshall Klaus’s wife.

⁶ This book—now in its third edition under the title *The Doula Book*—remains popular today, and is required reading for students in multiple doula training and certification programs.

The existence of so many other individuals offering social and emotional support to laboring women across cultures and time periods shows that at its most basic level, the role of the modern American doula in providing these forms of assistance is not a new one. What is unique is the professionalization of these services; that is, the idea that providing labor support is a practice requiring a specific set of skills, knowledge, and competencies deserving of both compensation and recognition by the public and other professional groups. The body of research described above showing the positive effects that social and emotional support by doulas can provide mothers and babies has certainly facilitated and perhaps even accelerated this process of professionalization, but there is more to the story than a chance discovery by physician researchers. A number of social and historical factors unique to the specific context of maternity care in the United States has led to the current historical moment in which doula care has begun to assert itself as both an independent profession and potential solution to many issues present within the healthcare system and its treatment of pregnancy and birth.

Social and Emotional Support during Childbirth in America: Colonial Era to the Present

The current attitudes, practices, and ideology surrounding pregnancy and birth in this country are the cumulative result of an expansive array of significant historical events, social changes, and advances in medical knowledge, technology, and professional dominance. Many historians, sociologists, and other researchers have participated in the creation of an extensive body of scholarship documenting the history of American childbirth from a range of theoretical viewpoints and methodological approaches—

though often with an eye to mostly white, urban, middle- to upper-class women's experiences (Wertz and Wertz 1977; Shaw 1974; Davis-Floyd 1992; Rothman 1982; Sullivan and Weitz 1984; and others). Synthesizing common observations from a range of birth scholarship, historian Nancy Schrom Dye aptly summarizes the history of birth and maternity care in America by dividing it into three major periods, which she defines as follows:

The history of childbirth in America can be broken into three periods. Until the late eighteenth century, birth was an exclusively female affair, a social rather than a medical event, managed by midwives and attended by friends and relatives. The second period, extending from the late eighteenth century through the first decades of the twentieth century, was a long transition between 'social childbirth' and medically managed birth. Gradually, male physicians replaced midwives and transformed birth into a medical event. By the 1920s, the beginning of the third period, this major transformation had been completed. The medical model of childbirth emerged unchallenged as the medical profession consolidated its control of birth management (Dye 1980:98).

Although limited in that it tends to overlook the experiences of women of color and other marginalized communities, Dye's three-stage framework remains useful for contextualizing the major events, innovations, and social changes that have defined American childbirth since the colonial era. Writing in the 1980s, however, she could not have anticipated the advent of yet another era in American childbirth—the one in which we find ourselves today. What follows is a brief summary of these four major periods in the history of American childbirth, with a particular focus on the availability of and value placed on social and emotional support at each stage. Taken together, these historical eras provide a number of insights about the current state of American maternity care and the relative position of doulas as providers of a complementary set of services and support.

The Social Childbirth Era

The first major period in the history of American childbirth begins with the colonial era and extends through the late eighteenth century. For more than 150 years from the founding of the first English colonies to the revolutionary period, a model that birth historians Richard and Dorothy Wertz call “social childbirth” reigned. During childbirth in this era “expectant women looked to female friends and kin for aid and comfort” with female midwives as their birth attendants (Wertz and Wertz 1977:1). Childbirth was a community event. Far from being limited to family and close friends, it “included women who were not members of the family and who were not paid to attend” (Wertz and Wertz 1977:4). These women provided emotional and practical support to laboring women by sharing advice and encouragement, as well as by taking care of household tasks and caring for existing children. Operating on the assumption of communal aid and reciprocity, friends and neighbors attended births with the knowledge that the favor would one day be repaid when they gave birth. Social and emotional support during and immediately after childbirth were thus a given for women in this period. With men excluded from both the process and the physical space where childbirth occurred, women enjoyed a rare and significant opportunity for the experience of “female solidarity” with their friends, family members, and neighbors (Wertz and Wertz 1977:4). The tradition of social childbirth represents the original form of strong social support by lay individuals during labor in the United States among populations of European descent.

Virtually all births in this era made use of midwives as a skilled birth attendant. They provided a valuable service to the community by caring for its pregnant and birthing women, and in return were generally held in high social regard. Some midwives

also provided advice and treatment for health issues unrelated to pregnancy, such as general illnesses, broken bones, or other injuries (Ehrenreich and English 1973). That a midwife was included among the passengers of the *Mayflower* speaks to their importance for the nation's earliest European settlers (Litoff 1978:4). In addition to social taboos which prohibited the presence or intervention of males in the labor room, some colonies and states passed laws actively forbidding their involvement. These norms and laws kept birth in the sole domain of women for many years, except in cases where physicians were brought in to manage recognized abnormalities or emergencies. For their part, physicians were largely uninterested in birth, which was believed to be "a natural process in which a minimal amount of specialized knowledge was required" (Litoff 1978:5).

Few primary sources remain documenting the work and education of the nation's earliest midwives, but from what does exist it can be deduced that women learned by apprenticeship to "[provide] moral support and encouragement to the parturient woman and, otherwise, let nature take its course" (Litoff 1978:6).⁷ Midwives rejected common medical practices of the time such as bloodletting and purging. Believing birth to be a natural process outside of human control, they allowed it to progress spontaneously and with minimal intervention. In the context of social childbirth, midwives brought experience and expertise from the many births they had witnessed and assisted with to offer a skilled presence in the labor room. Thus, the role of an early midwife was primarily one of knowledgeable support for the woman rather than active management of her labor. The primacy of social and emotional support over attempts to manage or intervene in the labor process has a clear parallel in the work of modern doulas.

⁷ Laurel Thatcher Ulrich's *A Midwife's Tale: The Life of Martha Ballard, Based on Her Diary, 1785-1812* is one notable example to the dearth of primary source information about the lives of the early American midwives.

Midwives maintained their exclusive status as birth attendants until the Revolutionary period. Beginning in the late eighteenth century, however, the social and professional landscape surrounding childbirth began to shift. These shifts mark the beginning of the second period in the history of childbirth identified by historian Nancy Schrom Dye: The transition from social childbirth to medically managed birth, and from midwifery to obstetrics.

The Transitional Era

Beginning in the late eighteenth century, slow but significant changes began to take place in the realm of childbirth for American women. As the name suggests, the transitional era was a time parturient women spent betwixt and between a number of people, places, and practices at the time of their labor—between midwives and obstetricians, home and hospital, passive support and active intervention, physiological process and pathology, the “natural” and the technological. The availability of social and emotional support during childbirth varied widely throughout this period, dependent upon a variety of factors including the type of birth attendant a woman chose and the location where her birth occurred. Perhaps the most striking characteristic of this period, however, is the emergence of the ability to buy a better birth. As the range of options for care provider, birthplace, approach to labor management, and pain relief grew, so too did stratification between the women who could access and afford such options and those who could not. Meanwhile, as new options emerged, others began to disappear—most notably the profession of midwifery. The transitional era thus represents a number of significant shifts in inequality among lines of class, race, and gender.

The rise of obstetrics and fall of traditional midwifery are two intertwined and significant narratives of the transitional era, and some of their lasting effects are still visible in the maternity care system today. Beginning in the late eighteenth century, traditional midwifery entered a period of decline as physicians sought to expand their scope of practice to include the management of childbirth (Wertz and Wertz 1977; Ehrenreich and English 1973; Litoff 1978; Sullivan and Weitz 1988). Originally called “male-midwives”, physicians who attended births claimed to offer a higher level of expertise and technical skills gained from their education in medicine, such as the use of forceps to aid delivery. The fact that male-midwives could claim these skills while female midwives could not was no chance occurrence. As medical schools began to spring up on American soil, “women were...systematically excluded from attaining a medical education at the precise time when knowledge of the scientific advances in obstetrics would have enabled them to become more competent midwives” (Littoff 1978:9). Aside from some classes and skill workshops which were occasionally made available to a select contingent of midwives who could afford them, formal education and training in midwifery and medicine was essentially closed to women, particularly women of color and those living in rural areas (Sullivan and Weitz 1978:7). This lack of formal education among midwives would become a key talking point for physicians and allies who would later seek to outlaw them completely in the United States.

Despite the fact that male-midwives had access to medical education that putatively made them more competent birth attendants, the reality of their clinical training in the subject was less than ideal. Many new physicians went into the experience of attending their first birth without ever having observed the process before (Brodsky

2008:99). While in Europe and particularly France midwives and physicians were trained alongside each other with a common belief that normal labor did not typically require intervention, “In America, where midwives were not trained at all and medical education was sexually segregated, medicine turned away from the conservative tradition and became more interventionist” (Wertz and Wertz 1977:63). Although many medical professors and textbooks continued to advocate for a policy of non-interference in childbirth except in cases of emergency, in practice it was difficult for new physicians to comply. Caught unprepared in the action-oriented role of a physician, these practitioners often “...resorted to instruments [such as forceps] in haste or in confusion...because physicians, whatever their state of knowledge, were expected *to do something*” (Wertz and Wertz 1977:65, emphasis added). The use of these interventions was certainly appropriate in some cases, but in others left women and infants with unnecessary and sometimes permanent injuries, or caused death (Sullivan and Weitz 1988:8).

Male-midwives initially faced strong opposition from both fellow physicians and the public. Opponents of intervention during normal childbirth criticized the use of what they called the “meddlesome midwifery” of male-midwives, referring to their high utilization of drugs, forceps, and other interventions to speed delivery (Wertz and Wertz 1977; Litoff 1978). Others argued that the mere presence of men in the labor room was indecent. That a man other than her husband should see or touch a woman’s intimate body parts was seen by many as scandalous and obscene. Both lay individuals and physicians published their thoughts and concerns about protecting the decency and virtue of parturient women in a drawn-out debate spanning the late eighteenth and early nineteenth centuries. Traditional woman midwives, meanwhile, were curiously silent

when it came to defending their position as birth attendants—at least in surviving records (Wertz and Wertz 1977:56; Sullivan and Weitz 1988:4-6).

In spite of moral panic and mounting concerns about unnecessary intervention among male-midwives, increasing numbers of women—particularly from the middle and upper classes—began opting for physicians instead of midwives as their birth attendants. This trend gained momentum for a variety of reasons. By 1828, male-midwives had a unique name that more fully separated them from the practice of midwifery: Obstetrician (Wertz and Wertz 1977:66). Medical schools regularly included obstetrics in their curricula, and advancements in knowledge and technology offered greater legitimacy to the field. The higher fees and prestige associated with physicians made their presence at a woman's birth a status symbol, attracting members of the urban middle and upper classes (Wertz and Wertz 1977:64-65). But far from only seeking the status a physician brought, many women hoped that a more skilled attendant would also protect them from the dangers of childbirth (Dye 1980; Sullivan and Weitz 1988; Wertz and Wertz 1977).

In spite of the strong (and easily romanticized) social support enjoyed by laboring women in earlier decades, “There is much evidence that birth was often a terrifying ordeal” (Dye 1980:99). Statistically speaking, most women would have known at least one other woman who had died, been injured, or lost a child during birth. Physicians, in turn, emphasized the potential risks and dangers birth presented and advertised themselves as the authorities in their diagnosis and management. Whether women chose obstetricians for safety, status, or a mixture of the two, the effect was a transformation in the whole experience of American birth; “this change marked not only a shift from a nonprofessional attendant to a professional one, but also a transition from a female-

controlled experience to a male-controlled one” (Dye 1980:100). This shift was illustrated not only by the substitution of obstetrician for midwife, but also in an altered social atmosphere. Although for a time most births continued to take place in the physical space of a woman’s own home, physicians barred female friends and family members from the room “in part because visitors undermined doctors’ authority, but also because in the increasingly privatized family life of the nineteenth century, the birth process ‘embarrassed both patient and physician’” (Dye 1980:102). Without even the social support of other women, the experience of childbirth fell even more fully under professional control. Childbirth in the care of a physician “was a secluded, private experience” (Dye 1980:101). Women traded the benefits of social and emotional support for the putative safety and expertise of an obstetrician.

Still, the option to purchase an obstetricians’ services was a fairly exclusive one. Obstetricians remained out of financial and geographic reach for many Americans, and midwives continued to attend the majority of births throughout the 19th century (Dye 1980:103; Morton and Clift 2014:56). There is also evidence that some middle- and upper-class women continued to hire midwives against the trend toward obstetricians out of a desire “to continue female birth rituals and preserve modesty[,] and because they trusted midwives’ noninterventionist practices” (Dye 1980:102). But eventually this changed as obstetricians began to actively crusade for the elimination of midwives. Their successful campaign effectively eliminated the option of a midwife-attended birth for the vast majority of American women until the reemergence of nurse-midwifery under physician supervision decades later.

Along with being part of a wider movement for the centralization of medical authority among “regular” physicians in the United States, the motivation for this endeavor was based in economics, racism, and sexism. In spite of charging lower fees, midwives were still obstetricians’ competitors in the market for patients (Dye 1980; Wertz and Wertz 1977). Furthermore, since upper-class women had mostly transitioned to using obstetricians as birth attendants, midwives primarily served the lower classes. By caring for poor women outside the hospital, obstetricians complained that midwives were limiting the availability of patients in charity hospitals from which medical students could gain experience (Sullivan and Weitz 1988:11). Although obstetricians had more passively criticized midwives for many years, around 1910 they began campaigning in earnest for their strict regulation and ultimate elimination from the field of birth (Dye 1980:104).

Midwives were vulnerable to the medical profession’s attacks for a variety of reasons. A major factor was their socially marginalized status. Although in colonial times midwives hailed from many different positions on the social ladder and enjoyed the respect of their communities, ideals of female delicacy and domesticity in the Victorian era had discouraged white and well-to-do women from pursuing any sort of occupation outside the home (Sullivan and Weitz 1988:11; Brodsky 2008). Consequently, by the early twentieth century “midwives were usually poor, untrained, immigrant or black women with low social status and little occupational prestige” (Dye 1980:103; Litoff 1978). Unlike physicians, who had the influential American Medical Association (AMA) as their advocate at the state and national level, midwives were independent practitioners without a formal organization to represent their interests. Faced with the white male-dominated profession of obstetrics, midwives were an easy target for public scorn and

physicians' calls for legislative action. A history of this period by Deborah Sullivan and Rose Weitz reveals the strongly negative rhetoric employed by physicians when writing about midwives in Boston newspapers during the early twentieth century:

In their writings, these physicians described the midwife variously as 'the typical, old, gin-fingering, guzzling midwife with her pockets full of forcing drops, her mouth full of snuff, her fingers full of dirt and her brains full of arrogance and superstition,' 'a relic of barbarism,' 'pestiliferous,' 'vicious,' 'ignorant, half-trained, [and] often malicious,' '[with] the overconfidence of half-knowledge...unprincipled and callous of the feelings and welfare of her patients and anxious only for her fee' (Sullivan and Weitz 1988:11).

Other campaigns against midwives played off of racism and ethnic prejudice.

Advertisements published in newspapers and other publications featured elderly Italian, Black, Irish, and Russian Jewish women with captions referencing their allegedly "filthy customs and practices," qualities of "ignorance and superstition...[from the] 'magic doctors' of the West Coast of Africa," and poor hygiene (Wertz and Wertz 1978:216). By contrast, physicians were portrayed as enlightened, modern, trustworthy, and safe. That this image did not necessarily correspond with their patients' statistical health outcomes was brushed aside.

Physicians' activism in this area was ultimately successful. In accordance with their urging, states passed laws that either banned the practice of midwifery altogether or instituted requirements so strict that virtually no lay midwife could meet them, with one notable exception to this rule being highly-trained Japanese midwives on the West coast, who were educated in their home country before immigrating (Dye 1980:104; Litoff 1978; Smith 2005). After 100 years of obstetricians slowly and gradually gaining ground in the domain of childbirth, the decline of midwifery and physicians' corresponding rise to dominance suddenly accelerated significantly:

As late as 1900, half of all children born in a given year in the United States were delivered with the help of a midwife attendant. Yet, by 1930 midwife-attended births had dropped to less than 15 percent of all births in the United States, and most of these were in the South (quoted in Morton and Clift 2014:56).

With childbirth now nearly the sole domain of obstetricians, the process of transition from social to medically managed childbirth was almost complete. The next major transition was that from home to hospital.

Up to the late nineteenth and early twentieth centuries, only poor and indigent women without a stable home to birth in were typically cared for in hospitals. Maternity hospitals were often unhygienic and dangerous places, with high rates of infection and maternal and perinatal death (Brodsky 2008:100). Women with the means to do so avoided these institutions, and obstetricians accommodated them by coming to their homes. This is illustrated by the fact that in 1900, less than 5% of American women delivered in hospitals. But as technology advanced and conditions improved, physicians began to advocate for hospital birth. Gradually increasing numbers of women were attracted by the promises of safety and new technologies for pain relief and aid in delivery. The woman-led Twilight Sleep Movement, which treated painless childbirth as a feminist issue, was an active partner in encouraging the transition toward hospital birth (Dye 1980:108; Kohler Riessman 1983). Hospital birth first rose in popularity in urban areas where hospitals were close by, but as cars became more common and accessible even women from rural areas began to travel to hospitals for their deliveries. By 1939, 50% of all American women and 75% of urban women were choosing to birth in hospitals (Wertz and Wertz 1978:133). Women from all walks of life were drawn into the normalizing force of obstetrician-attended, hospital-based birth. Even America's newest

residents, immigrant women, were quick to adopt the practice as a way of marking one's assimilation to an American way of life (Wertz and Wertz 1978:217). By 1960, 96% of all U.S. births took place in hospitals (Dye 1980:106; Wertz and Wertz 1978).⁸

The move from home to hospital further consolidated medical control of childbirth. Although the promise of pain relief and safety had initially made hospital birth attractive to many women, the lived experience of birthing in a hospital was not always a positive one. When birth occurred in the home, women were situated in familiar surroundings to which the obstetrician had to adapt his behavior and practice. The transition to hospital birth inverted this relationship. The hospital was a doctor's turf, and the hospital as an institution had control over the physical environment and conditions under which birth could occur. Women now had to adapt their behavior and expectations to the demands and possibilities of the unfamiliar setting of a hospital room and the obstetrician in charge of it, along with the accompanying hospital-wide procedures and protocols. In the space of a hospital and the role of a patient, women lost what little autonomy they had previously maintained over their births when the process took place at home (Brodsky 2008:130).

Upon admission, women's access to social and emotional support was limited to what the institution would allow. For decades, this meant no one from a woman's normal social milieu, including her partner or close relatives, was permitted to accompany her and offer support. At the close of the transitional era, the value of social and emotional support had been totally eclipsed by attempts to control and rationalize birth not as a

⁸ Hospital birth continues to constitute the overwhelming majority of American births today. In 2012, the most recent year for which data are available, 98.64% of all births occurred in hospitals (Centers for Disease Control and Prevention 2014).

social occasion or major life event, but a pathological, medically managed experience. So began the third era of American childbirth and maternity care.

The Technocratic/Medicalized Era

The end of the transitional era overlapped with the rise of the technocratic/medicalized era in the early twentieth century. By the end of World War II, however, the transition was complete, and the new era in American childbirth was in full swing. Birth had come to be considered a pathological, risky process best managed by a medical doctor in the carefully controlled environment of a hospital, where all the latest technological innovations in surgery, pharmaceuticals, and medical surveillance were at his disposal. So emerged the technocratic model of birth.

Technocracy describes a society where the use of technology and scientific knowledge is universally equated with progress. Technological innovation is assumed to uniformly improve upon what came before, making human life and activities more efficient, sophisticated, and generally better in every way (Davis-Floyd 1992; Turkel 1995). In the field of childbirth, as in medicine more generally, the 20th century gave rise to an explosion in new technologies and knowledge. New forms of anesthesia such as the spinal and epidural allowed women to remain conscious during their labor and delivery process while still providing highly effective pain relief, reducing the use of powerful sedatives from previous eras which impaired cognition and memory. These and other new drugs, machines, and procedures made the process of giving birth increasingly high-tech and specialized, and from a technocratic worldview therefore more efficient, safe, and modern. In fact, the hospital as a whole came to be seen as a “highly sophisticated

technocratic factory” where the mere presence of more advanced and abundant technology was universally assumed to indicate a higher quality of care (Davis-Floyd 1992:55).

Of course, many of the technologies and scientific knowledge discovered and employed by physicians during this period were positive, and in certain situations even lifesaving. But in spite of the fact that from a technocratic perspective the increased use and availability of advanced diagnostic and treatment technologies represented progress in the field of obstetrics, these changes yielded mixed results in the lived realities of women in maternity wards. The use of newer forms of anesthesia offers a compelling example. On one hand, forms of pain relief such as the epidural allowed women who wanted to avoid experiencing the pain of labor the opportunity to still remain conscious and aware, thereby increasing their ability to be present and participate in the birth process. On the other hand, having an epidural subjected women to further forms of restriction and monitoring of their bodies and mobility, and could have a significant impact on the outcome of their birth. Once a woman has had an epidural, she cannot get out of bed and walk around; she is catheterized and required to keep still. If the epidural is so strong as to completely eliminate feeling in the lower half of a woman’s body, she can no longer feel when her contractions are peaking in the second stage of labor (pushing). These factors can slow labor progress, prolong the second stage of labor, and significantly reduce the likelihood that a woman will have a spontaneous vaginal delivery, thereby making an instrumental or surgical delivery more likely (Thorp et al. 1993; Lieberman and O’Donoghue 2002).

Another noteworthy example is the use of electronic fetal monitoring (EFM). EFM units allow medical personnel to continuously monitor the strength and frequency of a laboring woman's contractions, as well as the heartbeat of the fetus. They are made up of two primary components: A device which is strapped onto the patient's abdomen, and a receiver which displays the information it receives from the device. The device is somewhat cumbersome and must remain properly placed in order to give an accurate reading, which limits the mobility of laboring women. While EFM provides a steady stream of information about the progress of a patient's labor and the status of her fetus, at times the continuous use of monitoring can lead caregivers to leap into action at even minor signs of trouble that would otherwise likely resolve on their own without intervention. Large-scale clinical trials and systematic reviews of the literature on continuous fetal monitoring during labor have shown that while reductions in infant health issues and mortality are low or nonexistent, the chance that a woman will have a cesarean delivery increases (Thatcher, Stroup, and Chang 2006; Vintzileos et al. 1995). Use of EFM also has important implications for the availability of social and emotional support from nurses and other caregivers, because it enables them to remotely view information about a woman's labor without having to physically examine her or even be in the same room. This ability can reduce the amount of face-to-face care that a given patient receives while in labor, and shifts the focus from the individual in labor to the machines interpreting signals from her body. For the women whose bodies are being monitored, the experience of being connected to an EFM unit can be alienating and fraught. One woman's experience of EFM in Robbie Davis-Floyd's study of hospital

birth provides a striking example of how some women have experienced this phenomenon:

As soon as I got hooked up to the monitor, all everyone did was stare at it. The nurses didn't even look at me anymore when they came into the room—they went straight to the monitor. I got the weirdest feeling that *it* was having the baby, not me (Davis-Floyd 1992:107).

The feelings described by the woman above illustrate a noteworthy relational consequence of the technocratic worldview. Although the goal of everyone involved in patient care on a maternity floor is presumably to ensure that mother and baby are safe, healthy, and cared for, extensive use of technological monitoring and intervention places an intermediary between a patient and her caregivers. She is often not interacted with directly; rather, technology mediates her relationship with care providers, dramatically changing the patient-caregiver relational dynamic and limiting the amount and nature of person-to-person support she may receive. In the technocratic era, technology and professional expertise take center stage; the laboring woman in the room is almost incidental, playing a mere supporting role in the medical drama which unfolds around her hospital bed. This places her in a passive role; “when the *doctor* is delivering the baby, the mother is in the passive position of *being delivered*” (Rothman 1982:174).

After World War II, a number of movements sought to push back against aspects of the technocratic worldview with varying degrees of success. The childbirth education movement, for example, sought to prepare women to cope with childbirth through advance preparation and skill-building instead of pain-relieving drugs. One of the most well-known and popular childbirth education methods, Lamaze, focused on “psychoprophylaxis,” or the idea of preparing mothers for what to expect during birth before labor begins and then providing assistance with coping and support during

childbirth. In the European context where Lamaze was created, a specially trained nurse called a *monitrice* provided prenatal education and then went on to provide extensive social and emotional support during the birth, reminding the laboring woman of skills for remaining calm during contractions and staying focused. In the United States, staffing infrastructure or precedent for such a model of nurse-supported birth did not exist; such extensive social and emotional support were simply not considered part of a nurse's responsibilities. Husbands were substituted instead as "labor coaches," accelerating the progress of their admission to the labor rooms in American hospitals where their presence had previously been prohibited (Leavitt 2009).

The childbirth education movement, including Lamaze, did offer women a means for feeling as though they were taking a more active role in their labor and birth experience. Additionally, the movement's contribution to pressuring hospitals into allowing laboring women to bring partners, friends, and other family members into the labor room re-opened the possibility of receiving social and emotional support from loved ones during parturition for many American women. However, it failed to challenge more fundamental issues present in the maternity care system and its technocratic ideology. Students of Lamaze were not encouraged to challenge their physicians, but rather to cope with the maternity care system as it was. Instead, Lamaze's printed materials and certified instructors urged women and their partners to accept their physician's recommendations without protest, even if they seemed arbitrary or went against their personal wishes (Bing and Karmel 1961:33). Although Lamaze was just one of many childbirth education programs, its approach to dealing with the institution of medicine is fairly representative of mainstream childbirth education. Ultimately, most

childbirth education was complicit with a medicalized, technocratic approach to childbirth; the movement sought to “humanize medical management—not do away with the medical approach, but make it more pleasant for women, more responsive to their needs” (Rothman 1984:170).

The Current Era

The current era in American childbirth shares many characteristics with the previous one. Obstetrics—and the practice of medicine in general—is still ruled by a technocratic ideology. Nearly all births in the United States continue to take place in a hospital setting, and though a number of reforms to the strict and invasive medical birth routines of the postwar era have occurred, the process remains a medicalized event (Conrad 2007:158). In spite of these more static aspects, however, a number of significant changes have occurred with respect to birth and maternity care. Many of these changes are closely related to shifts and structural changes within the wider American healthcare system as a whole, as well as influences and phenomena external to the institution of medicine. With the advent of the Internet, for example, an almost limitless wealth of information about health and the body is now available to anyone with access to a smart phone, tablet, or computer. Astute patients are able to self-educate about their health needs, discuss their conditions and treatment experiences with others, and read reviews of hospitals and care providers before ever stepping into an exam room. This access to information extends to knowledge about pregnancy and childbirth, and as healthcare researchers Brian P. Hinote and James Adam Wasserman note, “This fracturing of health knowledge raises important question (and opportunities) for a variety

of childbirth professions as they navigate the rapidly changing world of health and medicine” (2012:70).

In today’s healthcare landscape, consumer advocacy plays a role of increased importance. Of course, consumer movements are far from novel in either the healthcare field in general or childbirth specifically—the Twilight Sleep Movement of the Victorian era is one notable example from the past. What has changed is the strength, scale, and ultimate influence of such initiatives. In past eras, individuals who had experienced suboptimal care or who desired a certain type of service could easily feel isolated from others who shared their plight, but with the Internet and social networking today it is possible to find compatriots and start a social movement with just a few clicks and keystrokes (Barker 2008; Brown et al. 2004; Garrett 2006). Consequently, the potential magnitude of health social movements has increased exponentially in the current era of American healthcare and childbirth.

It is not only the ease of initiating and participating in health consumer advocacy movements that has changed; the responsiveness and accountability of the institution of medicine to such phenomena has also increased. In the so-called “Golden Age of Medicine” of the post-WWII era, the authority of physicians was extremely powerful—as the saying went, doctor knew best, and he was relatively free to practice as he pleased (Starr 1982). Today’s medical system is worlds apart from the days of independent practitioners making house calls and dispensing unquestioned advice. Most physicians are beholden to a complex array of external factors including their hospital employers, the insurance companies that reimburse for their services, and government regulators (Zuger 2004). The changing economics of healthcare have resulted in altered incentives

for both individual care providers and the larger medical systems in which they operate. Patients are no longer just charges in the care of a medical provider—they are also customers of hospitals, health systems, and insurance companies. This paradigm shift has led to an increased emphasis on patient satisfaction, a subjective measure of success that depends upon not just keeping patients healthy, but also happy. Patient satisfaction is highly emphasized within the Affordable Care Act (ACA), and achieving high scores has significant financial implications for hospitals and healthcare networks, as well as the compensation and professional advancement of individual practitioners (Millenson and Macri 2012).

These changing economic incentives thus carry with them a heightened motivation to heed patient requests in order to keep customers happy and satisfied. Hospitals have been redesigned to be more comfortable and visually pleasing for patients and their families (Janssen et al. 2001). These aesthetic changes serve to enhance the experience of being in the hospital in hopes of improving patients' perceptions of their care. Allowing for the presence of doulas in the labor room is yet another means of responding to the desires of patient/customers in contemporary maternity wards; if the customer wants to bring a support person with them into the labor room, a customer-service oriented model of healthcare is disposed to acquiesce where a more authoritarian model might not.

Marginalized Communities and American Childbirth

Although the major historical shifts and advancements in knowledge and technology eventually came to impact virtually all American women in some way, the

history of childbirth outlined above does not apply equally across lines of race and class. Rural communities and communities of color relied heavily on midwives and community support for birth beyond the time that more privileged women and women in urban areas began taking advantage of obstetric technology and birthing in hospitals. Even in urban areas, women of color struggled to gain access to the same standards of care afforded their white counterparts. For example, although 96 percent of births in Chicago during the 1950s took place in hospitals, two-thirds of the city's hospitals did not admit African American women, leaving them to labor in the few overcrowded, under-resourced hospitals that would care for them (Leavitt 2009:12). Some groups today continue to be denied even a minimally adequate standard of perinatal care, let alone additional amenities like the services of a doula.

Firsthand accounts and historical documents detailing how marginalized communities handled childbirth semi-independently of the changes and innovations seen in urban American from the transitional era onward are fairly rare, which is indicative that such stories and voices were not valued at the time. In the South, Black lay and nurse-midwives were deputized by local public health departments to care for the women in communities where formally trained doctors and nurses were scarce (Fraser 1998; Smith 1995). The work of one nurse-midwife, Maude Callen of South Carolina, was chronicled by a popular photojournalistic essay in *Life* magazine in 1951 (Fraser 1998:5). Two years later, the Georgia Department of Public Health released a hybrid documentary/educational film called *All My Babies: A Midwife's Own Story* focused on the work of Mary Cooley, a lay midwife in Albany, Georgia who had delivered more than 1,400 babies over the course of her career (Stoney 1953). These photos and film

provide brief but insightful glimpses into the lives and work of Black Southern midwives at a time when more privileged and urban women had largely transitioned to obstetrician-attended, hospital-based, medicalized births. Black Southern midwives practicing in the first half of the twentieth century were typically well-respected by their communities and begrudgingly recognized as necessary by physicians and public health officials. As influential members of their communities, midwives acted not only as birth attendants, but also as representatives of the public health departments which oversaw their work. In her book on Black women's health activism, Susan Smith notes that the need for birth attendants in rural areas created a unique opportunity for Southern lay midwives that was nonexistent for their Northern and Midwestern counterparts in that they were able to “[use] the opportunity provided by government regulation to become important health workers well beyond their midwifery practice” (Smith 1995:118).

On the West coast, Japanese-American midwives, called *sanba*, provided skilled labor support for women in their immigrant communities using education and values they brought with them from their homeland. Compared with lay midwives in the United States, *sanba* were highly qualified and professionalized thanks to Japan's national standards for the education, licensing, and practice of midwives. The work of *sanba* in America continued even as state laws sought to tighten regulations on midwifery or outlaw it altogether, beginning with the earliest waves of Japanese immigration in the late nineteenth century and extending through the close of World War II (Smith 2005).

Unfortunately, in spite of decades of change and attempted healthcare reform measures, many communities remain marginalized within the maternity care system today. As Peter Conrad notes, reforms and improvements to hospital birth procedures and

maternity care have “affected middle- and upper-class women much more than poorer women” (Conrad 2009:158). Inequalities in the accessibility and quality of maternity care for poor women, rural women, and women of color persist, with serious implications for maternal-infant health outcomes (Orsi, Margelios-Anast, and Whitman 2009). In her ethnography of pregnancy in a New York women’s health clinic, Khiara M. Bridges observed the many ways that pregnancy remains a site of racialization for Black women in particular, influencing the attitudes of women’s caregivers and the quality of care received (Bridges 2011). Aside from the occasional volunteer program or independent doula offering pro bono services, the benefits of continuous labor support from a professional doula remains inaccessible for most poor women, rural women, and women of color in America today.

Doula Care in a Social-Historical Context: Buying a Better Birth

Beginning with the dawn of the transitional period in the late eighteenth century, major changes in maternity care have created the ability for people with means and privilege to “buy a better birth.” Of course, what constitutes “a better birth” has changed dramatically with time and the growth of scientific knowledge and medical advancements. At one point, buying a better birth meant employing an obstetrician rather than a community midwife. Later, it meant being able to continue giving birth at home while poorer women were relegated to squalid, cramped charity hospitals or isolated, resource-poor rural homes. As hospital birth became safer and recommended by doctors, buying a better birth came to mean laboring in a hospital with access to pain relief in the form of Twilight Sleep, sedatives, and later, epidural anesthesia. Today, doulas represent

one of the latest ways by which a woman and her family can effectively buy a better birth experience.

But why doulas, and why now? I argue that the specific social and historical context surrounding birth in the United States has created both a particular need and a desire for additional support during pregnancy and birth. When birth moved from the home to the hospital during the twentieth century, it effectively entered a black box. Removed from the rhythms of everyday life outside the hospital, the process of labor and experience of supporting women through it became invisible and inaccessible to lay people. Birth was the business of doctors and to some extent nurses—not average women and their families. Additionally, considerable decreases in women's lifetime fertility have worked to limit individuals' knowledge of birth even if they have experienced it personally; after all, the cumulative wisdom of six births is greater than that of one or two. After multiple generations of giving birth under such conditions, Americans' collective knowledge of how to socially and emotionally support parturient women was effectively lost. Childbirth education classes seeking to educate women's partners about support techniques offer one potential solution, but are often effectively co-opted by hospitals to become more oriented toward *patient* education, not childbirth education (Rothman 1982; Morton and Clift 2014).

Such a loss of generational knowledge is not unique to birth, nor to the American context. Anthropologist Nancy Scheper-Hughes describes the process by which multinational corporations promoted formula feeding in Brazil so aggressively that breastfeeding became socially stigmatized, leading to a loss in women's collective knowledge of how to effectively breastfeed their children (Scheper-Hughes 1993:321-

326). With fewer and fewer mothers choosing to breastfeed across multiple generations, women were unable to turn to their own mothers and grandmothers for advice even if they wanted to breastfeed or could not afford formula, because over time such knowledge had faded away. Knowledge of social and emotional support during labor, once an activity in which virtually all women of a certain age in colonial communities participated, was similarly lost when generations of women gave birth in environments where such support was not permitted. Most women can no longer reach out to those within their immediate network of friends and family for the support they want and need, and the focus of their care providers within the hospital is trained on only the “medical” (that is, measurable) aspects of their birth experience at the expense of subjective, unquantifiable aspects. For support of their social and emotional needs during childbirth, women must look beyond their usual milieu to find someone with the proper skill set.

Doulas have appeared at this particular historical moment as a solution to this problem. In their social history of doula care, Morton and Clifton characterize the birth doulas as a “uniquely American response to changing maternity care” (2014:98-99). I would take this observation a step further by claiming that doula care is not only uniquely American, but also uniquely capitalist. In a maternity care system where many obstetric practices remain routine in spite of evidence advising against their use, where women continue meet resistance when advocating for their personal wishes and desires for birth, and where maternal and child health outcomes remain considerably poorer than those observed in other industrialized countries, women with means can now purchase a chance at a better birth experience through the services of a doula. Those who cannot pay the price or find a volunteer doula are left to deal with the maternity care system as it is.

4. Findings

This chapter contains insights gained from qualitative interviews with five professional birth doulas currently practicing in Southern Maine. These doulas are not a representative sample of doulas in the United States, or even in the state of Maine. In spite of the limitations presented by such a small sample, however, their experiences are rich and full of details that provide valuable information about their role within the local maternity care context, and in some ways also the wider national healthcare landscape of which it is a part. What emerges is an understanding of their work and role within the individual hospitals and wider maternity care system where they carry it out, including their experiences and preferences within a variety of hospital spaces, their relationships with the care providers and nurses who attend to their clients, the client populations they serve as well as those they struggle to reach, the ways in which they help their clients negotiate the process of giving birth and receiving care in a hospital setting, and their efforts to empower their clients as both patients and parents. These findings reflect the tension between the individual-level impacts that doulas are able to achieve with their clients and the more systemic issues within maternity care that they are less able to influence, such as stratification of care among racial and socioeconomic lines.

The Doulas

In terms of race and gender, all five of the doulas interviewed for this project identified as white women. In spite of their demographic similarity, however, each doula had a unique story to tell about her work: How she came into it, her approach to working with clients, her experiences as a doula, her view of her work within the wider maternity

care system, and plans or vision for the future. At the time of their interviews, this particular group of doulas had collectively attended over 100 births since beginning their respective careers as birth doulas.

Sarah, age 31, had attended 24 births at the time of her interview.⁹ Through her career as a massage therapist with a specialty in pediatrics, she became involved in hospice work, bereavement, and infant loss. After hiring a doula for support during the birth of her second child, she became interested in entering the profession herself. As a doula and hospice worker, Sarah seeks to “bridge the gap between birth and death.” Consequently, she only accepts clients with high-risk pregnancies, specializing in cases of “multiples, or stillbirths, or infant loss and bereavement births.” Sarah’s specialization in high-risk birth is unique not only among the doulas in this study, but the profession more generally.

Lisa, age 55, had attended 30 births as a professional doula at the time of her interview. Her interest in birth began at an early age, and as a teenager she carried out an extensive school project at a rural North Carolina hospital, where she assisted with over 40 births. Though at one point she dreamed of becoming a midwife, she ultimately became a surgical technician in the women’s health field instead. Over the course of her career she volunteered extensively in free clinics and community health centers. Eventually she earned a master’s degree in hospital administration and transitioned into management roles as a clinic administrator and nonprofit board member. At age 50, unsatisfied with her administrative work, she decided to return to more hands-on service by becoming a professional birth doula. Because Lisa has a flexible primary job which allows her to make her own hours and work from home, she is able to offer the vast

⁹ The names of all birth doulas in this study have been changed to protect their confidentiality.

majority of her doula services pro bono. By partnering with a local homeless shelter, she has set up a system by which social service workers and clinics refer women in need to her for support during pregnancy and birth. Lisa's extensive volunteer work as a doula is quite unique, since many doulas must rely on income from their clients to stay afloat both personally and professionally.

Emily, age 26, had attended 28 births at the time of her interview. As an international studies major in her undergraduate years, Emily attributed her love of working with women in part to her experiences studying abroad in "matriarchal, indigenous" societies. A couple of years after graduating with her bachelor's degree, Emily came across a copy of Ina May Gaskin's *Guide to Natural Childbirth* on a friend's coffee table. She found the birth stories contained in the book incredibly moving: "It was really just one of those moments for me where everything kind of made sense, everything came together. I was crying, it was a very emotional, totally visceral experience, and that was one of the first introductions to birth that I had." This experience inspired Emily to consider becoming a midwife, but at the time she had not had much exposure to birth. Becoming a doula first seemed like a logical means of gaining more direct experience before seriously pursuing midwifery as a career. She is currently working on completing prerequisite courses to prepare for a nurse-midwifery program.

Allison, age 37, had attended 20 births at the time of her interview. A self-described "birth junkie," Allison was inspired to become a doula by her own successful unassisted home birth experience, which she said left her feeling "impassioned" to do more in the world of pregnancy and birth. For Allison, doula work is intimately tied up with feminism, women's empowerment, and a historical legacy of "woman-powered

healing arts.” Some, but not all, of her clients were of a lower socioeconomic status, and she professed a special enthusiasm for working with families in need in spite of the reality that it “doesn’t pay the bills.” Having spent time as a home birth midwife’s apprentice, Allison had the most experience with out-of-hospital births among doulas in this study.

Melissa, age 40, had attended 40 births at the time of her interview. Her interest in doula work was based in a passion for working with women at such an important point in their lives, as well as her own personal experiences with pregnancy and birth. After her first pregnancy ended in an emergency cesarean section, Melissa hoped for a vaginal birth after cesarean (VBAC) with her second baby. When hospital policy prevented her from being able to pursue a VBAC at the regional hospital in her area, she transferred care to a different hospital where her ideal birth would be possible in spite of its location over two hours from home. She refers to her second birth as her “victorious VBAC” because, as she put it, “I fought a battle...I fought the system, I fought the man and I won [*laughs*]. I felt very victorious in the end. It was a very difficult birth, as births go, but I felt very empowered.” Other women from nearby communities hoping for a VBAC in spite of hospital bans on the practice began contacting her for advice, and Melissa’s career within the field of pregnancy and birth began—first as a childbirth educator, and then as a doula.

The Maternity Care Context of Southern Maine

Pregnant women seeking prenatal care and a place to give birth in Southern Maine can choose from a range of hospitals, three freestanding birth centers, or a home

birth. Among hospitals, women have the option of a nonprofit Catholic hospital or a large academic medical center situated in an urban area, or a number of smaller regional hospitals which primarily serve the immediate communities where they are located. Area birth doulas work in virtually all of these hospitals at least occasionally. The doulas included in this study had much to say about the hospitals in which they frequently attended births, and several clear patterns emerged relevant to the reputation of each hospital with respect to its staff, resources, and approach to maternity care. These details are important because they represent the context within which professional doulas enact their work with clients within the medicalized setting of a modern hospital labor and delivery floor. A brief description of each hospital, its defining characteristics, and reputation among the doulas in this study is below.¹⁰

Saint Margaret's Hospital

Saint Margaret's Hospital is a Roman Catholic, nonprofit medical center located in an urban area in Southern Maine. As the third largest hospital in the state, it provides a wide range of services and specialties in addition to maternity care. Saint Margaret's labor and delivery unit occupies an entire floor of one of its main buildings. Its recently renovated rooms are set up in accordance with a progressive labor, delivery, recovery, postpartum (LDRP) model, meaning that patients remain in the same private room from admission through discharge rather than being transferred to a separate postpartum room after the birth, as was typical in the past. The hospital website takes care to advertise the maternity floor's many amenities, including spacious rooms with Jacuzzi tubs, day beds where family and friends can rest, free Wi-Fi, and room service.

¹⁰ All hospital names and identifying characteristics have been changed.

Doulas felt positively toward Saint Margaret's for a number of reasons. A well-respected midwifery practice and a group of obstetricians known for having a more woman-centered perspective on childbirth deliver at Saint Margaret's, and multiple doulas commented on their affinity for working with those particular physicians and midwives. In contrast to other local hospitals, Saint Margaret's also has a stated commitment to one-on-one nursing care for their laboring patients, and because Saint Margaret's is not a teaching hospital, doctors and midwives work directly with nurses; there are no residents to act as intermediaries. One doula in particular, Emily, spoke at length about how she had observed a higher level of respect for nursing staff at Saint Margaret's which seemed to correspond with higher job satisfaction among their ranks:

...at Saint Margaret's, there's the doctor and then the nurse, and the doctors and the nurses work very closely together, nurses are highly respected, they are the [doctors'] go-to [person for information about a patient's status].

As is discussed in more detail below, job satisfaction among nursing staff was seen as a factor which could greatly influence doulas' experiences working in hospital settings, so the perception of happier nurses at Saint Margaret's represents a significant benefit.

The doulas also appreciated aspects of the built environment Saint Margaret's provided for their clients. Allison emphasized the importance of its "coziness" relative to other local hospitals where women might birth:

Oh, Saint Margaret's. It's just so cozy... I guess that's why I prefer Saint Margaret's. It feels homier, the space definitely feels homier, I think the rooms are shaped differently... I think the ceilings are a bit lower, and there's carpeted hallways, whereas at Academic Medical Center there's not... There's something cozy about that. I think coziness is really important, because if you look at animals, like what does a dog do when it's gonna have its litter of pups? It's not gonna sit here under this bright light in the middle of the kitchen while we're all standing around and have

puppies. No, it's gonna climb under the table and find the darkest spot possible. So the coziness aspect of the hospital is really nice.

From Allison's viewpoint, the "cozy" environment provided by Saint Margaret's made for a location more suitable to giving birth than the bright, sterile aesthetic often associated with modern hospitals.

Academic Medical Center (AMC)

Academic Medical Center (AMC) is a large, nonprofit teaching hospital located in an urban area. As the home of one of Maine's three neonatal intensive care units (NICU), it attracts a greater proportion of high-risk patients than Saint Margaret's or any of the regional hospitals which serve smaller cities and towns in the surrounding area. Unlike the LDRP room model employed by Saint Margaret's, AMC uses a more conventional system where women labor, deliver, and recover in one room, then are moved to a separate postpartum space for the remainder of their time in the hospital. Although perhaps not as luxurious or "cozy" as those advertised at Saint Margaret's, rooms at AMC are spacious and recently renovated.

Although the doulas in this study tended to prefer Saint Margaret's over AMC, they acknowledged that there are certainly cases where AMC is the best place for a woman to give birth. AMC's advanced technological capabilities and in-house NICU essentially made it the default hospital for patients with high-risk pregnancies. Because most complicated deliveries in the area occur at AMC, the staff are experienced in managing abnormal circumstances and medical emergencies. Although Allison expressed a strong preference for attending births at Saint Margaret's, she made a point of acknowledging AMC's unique value within the local maternity care context:

I think it's really wonderful, AMC being the biggest, best hospital in Maine, you know, there's a time and a place for technology and science, and the wonders of medical science. There is definitely a time and a place for that.

The "time and place" for a birth at AMC was not limited strictly to those involving complicated or high-risk pregnancies. For some clients, the presence of advanced emergency medical technology is comforting, making AMC the most comfortable place for them to give birth without experiencing undue anxiety. In spite of AMC's positive attributes, however, doulas, were quick to point out certain drawbacks. Perhaps because of its generally higher-risk population, AMC's protocols for labor and delivery are more strict than at other area hospitals, which doulas found frustrating. One of their common complaints centered around the mandatory placement of a Hep-Lock or IV in the arm of every patient. As Sarah put it:

[At AMC] it's standard protocol for you to have a Hep-Lock administered, so an IV administered when you're admitted to the OB floor. That's a pain in the ass. No one wants an IV in their arm, they're already uncomfortable. They want to be able to walk around without carrying a little thingy. It's annoying. It's protocol, though.

From the perspective of doulas, the placement of a mandatory IV for every patient was irritating and cumbersome for their clients, and by extension for them as well. That other hospitals did not have the same requirement made the protocol seem all the more arbitrary and frustrating.

Generally speaking among the doulas in this study, AMC was associated with a more intervention-oriented, technocratic birthing culture. Some doulas also perceived lower job satisfaction among AMC nurses compared to those found at other hospitals. Emily attributed this to the added bureaucracy inherent in AMC's status as a teaching hospital; nurses were beholden not only to attending physicians and midwives, but also

residents. It is also possible that the higher-risk environment of AMC's labor and delivery ward in comparison with other area hospitals creates added stress which impacts their professional satisfaction.

Regional Hospitals¹¹

Patients who do not want to deliver at either of the large, urban hospitals in Southern Maine can choose to birth at a number of smaller, local hospitals. The doulas in this study did not express strong feelings for or against attending births at these types of hospitals. As with any maternity care option, there are both advantages and drawbacks for patients. For individuals with low-risk pregnancies that do not require access to the resources of a larger hospital, regional hospitals can be a convenient, close-to-home option for maternity care within the community. Nurses at the larger medical centers frequently moonlight in smaller regional hospitals, so doulas can often identify familiar faces among the staff even on labor and delivery floors they visit infrequently.

While convenient and often more familiar to women from the communities they serve, the smaller size and comparatively limited resources of regional hospitals can present some challenges. Labor and delivery rooms are typically smaller and lack the amenities present in larger hospitals, such as bathtubs where women can labor in water. Staffing can also present an obstacle to women seeking certain birth options, such as a vaginal birth after a cesarean section (VBAC). Guidelines put forth by the American College of Obstetricians and Gynecologists (ACOG) recommend that hospitals offering VBACs have an anesthesiologist onsite 24/7, a requirement that is impossible for most

¹¹ These hospitals had many things in common, so identifying them individually in a manner similar to Saint Margaret's and AMC would have been redundant. For simplicity's sake, they are represented here as a category.

small hospitals to meet. Under these circumstances, women seeking a VBAC must either agree to a repeat cesarean section at their local hospital or seek care at a larger medical center that can meet the requirements necessary to offer VBAC. In cases where the choice of hospital would limit a client's options for birthing, several doulas stated that they would encourage their clients to explore their options at other hospitals further from home. For low-risk pregnancies where the relatively limited resources of local hospitals seemed like less of a potential issue for clients, the doulas were ambivalent toward them.

Doulas in the Hospital

One of the most unique aspects about birth doula care as professional labor is that it is often situated in a space where the doula is a third party. They carry out much of their work with clients on the professional turf of physicians, midwives, nurses, and other hospital personnel as guests within the labor room. This marginal status puts them in a precarious position, since whether or not they are permitted to remain with a client in the hospital is up to the discretion of the hospital staff who happen to be working on a given day or shift when a doula's client is in labor. Given these realities, it came as no surprise that the doulas in this study had much to say about their experiences working in hospitals alongside physicians, midwives, and nursing staff.

Care Provider Preferences

Within the maternity care system that currently exists in the United States, pregnant and laboring mothers seeking a hospital birth have the choice between a certified nurse-midwife or an obstetrician as their provider for both perinatal care and

labor and delivery. While in some regions the ability to choose a provider may not exist or may be limited—for example, in areas where there are no midwives or a small selection of care providers in general—pregnant women in Southern Maine (and particularly the greater Portland area) enjoy a relatively wide range of choice in the type of care provider they can select.

Since midwives are typically assumed to be more aligned with a low-intervention approach to birth that provides a higher level of emotional support and encourages vaginal delivery whenever possible, it may seem reasonable to assume that doulas prefer midwives over obstetricians as care providers for their clients. For some doulas in the study, this assumption turned out to be true. When asked if she had a preference in provider, Allison emphatically replied:

Yes! I love working with midwives. Definitely. It doesn't even have to do with them being women, because I've had women doctors that I've been at births with where I'm just like, "What?! You *have* a vagina, and you're telling this poor mom to X, Y, Z?" So that has nothing to do with it. Midwives are [typically] trained to think about the body more holistically, you know, as a whole structure and to think about what the baby's doing, and your emotions, and your hormones, and I don't know. They're awesome.

When asked more about her preference toward midwifery care, Allison expressed an appreciation for what she saw as midwives' greater emphasis on informed consent and collaboration with their patients, rather than the authoritative approach she associated with many obstetricians:

They're not pushing mom to do certain things. If mom brings something up, you know, "I want some pain medicine." Then they'll maybe even just ask her questions like, "Are you sure?"

By taking the time to ask questions and clarify their patients' desires in situations like the hypothetical one above, midwives offered what Allison perceived to be a higher level of

social and emotional support for her clients under their care. She clarified that the true difference she saw between midwifery and obstetric care was not in technical expertise, but in the more social elements of providing care. Allison even mused that the midwives at one particular practice were so attentive that perhaps her presence as a doula was occasionally rendered unnecessary:

It's really funny, because—and I'll talk about [SAINT MARGARET'S MIDWIFERY PRACTICE] here specifically—the births that I've been to with them, I'm not even sure that those clients would even need a doula, because they [typically] have awesome nursing support... [and] really, really great midwives. And obviously the midwives have maybe have other moms birthing at the same time or something, so they can't always be in the room, which is why a doula's consistent care is needed, but [otherwise] the midwives are right on board.

Like Allison, Emily also expressed a strong preference toward working with midwives, even going so far as to say that she had “seriously considered” not accepting clients unless their care provider was a midwife or an obstetrician from one particular practice whose physicians she found sympathetic. She explained that “Most people who hire doulas want to have a natural [i.e. vaginal] delivery, and there's choices that the care provider can make...that can really influence that.” Based on her experiences, Emily felt that midwives were more likely to make choices that allowed their patients the best possible chance at a vaginal delivery. She gave examples of instances where an obstetrician might pressure a laboring woman to accept an intervention such as medication or a surgical procedure, but a midwife might choose to simply monitor the situation closely to see how things progressed on their own before taking action. A diligent doula who maintained careful records of data and facts from each birth she attended, Emily was able to offer insights based on her own investigations comparing midwives and obstetricians:

I've never seen a C-section with midwives before. [Approximately half of the births I have attended] were with midwives. So the fact that it's so skewed, and I've only had one woman who was really high-risk, really shows that treatment may really influence the outcome.

At another point in the interview, Emily offered up some even more concrete statistics about the differences she had observed between birth outcomes for her clients with midwives versus obstetricians, based on her personal records from past births attended:

I've attended about equal amounts of births with midwives and OBs, and with the midwifery group, 76% of the women, all low-risk, had a natural delivery, so nothing involved. 76%; that's pretty good. OBs, only 45%. So not even half, compared to 76%. In the midwifery group I had a 9% induction rate, in the OBs I had, um, a 36%, 35-36%. I've never seen a C-section with midwives, I've seen many C-sections with OBs. That's something that was said to me up front is that OBs are much more likely to get themselves involved than a midwife. Midwives have a lot of patience, which is very important in birth, and I have seen that.

For Emily, a preference toward working with midwives was supported not only by her memories and personal experiences as a doula, but also by the data she had taken the initiative to collect and analyze about their practices and comparative outcomes. Though they may be subject to a certain degree of selection bias, her findings supported stereotypes about midwives and obstetricians that she had heard early on in her career as a doula; that is, that midwives are patient and less likely to intervene, while obstetricians are less patient and oriented toward intervention.

Sarah, a doula who works exclusively with high-risk patients, had a different take when it came to her personal preferences regarding midwives and obstetricians.

I wouldn't say that I would much rather birth with a midwife than an OB, believe it or not. Because in high-risk birth, when it comes down to the nitty-gritty they're gonna say the same thing. It's not gonna matter if they're a midwife. The journey on how we got there is what matters, but it's my job to make sure that the journey and how we got to that outcome had X, Y, and Z in it. Or at least we talked about X, Y, and Z if it wasn't

present. So maybe a midwife makes that journey a little bit easier because they're willing to explore those options, but I don't think it matters.

As a doula who worked with women whose pre-existing health conditions, complicated pregnancies, or other risk factors automatically exposed them to increased medical monitoring and intervention, she perceived provider differences to be less important. In a situation where some kind of intervention during birth seems virtually inevitable, the low-intervention tendencies of midwives are therefore rendered less relevant according to Sarah.

Like Sarah, Melissa did not express a strong preference toward one or the other type of provider. In her view, the personality and individual style of practice defined providers more than their professional training and credentials:

I would say there certainly are providers that I feel like are far more woman-friendly than others. There are providers that I feel like are far more open to women having autonomy over their own body. But I've worked with extraordinarily kind, compassionate, open-minded male obstetricians, and I've worked with incredibly narrow-minded female midwives. And so I wouldn't say across the board that you should always see this kind of a provider. I feel like there's a huge spectrum there.

Although she disagreed with some of the other doulas in that she did not feel that one type of provider was generally more ideal than the other, much of what Melissa expressed regarding the importance of an individual care provider's style and approach to birth was echoed by every respondent. Even if a strong pattern of differences between midwives and obstetricians was perceived by a given doula, each one acknowledged that there are exceptions to every apparent rule based on the provider's personal characteristics.

Encounters with Nursing Staff

Whether a patient elects to receive care from a midwife or an obstetrician, in any hospital birth the nursing staff are guaranteed to play a key role in the experience for both patients and their doulas. In comparison with midwives and obstetricians, nurses generally spend significantly more time providing direct patient care, advice, and support. Given their critical role and much more frequent presence at the bedside during labor and delivery, maintaining positive relationships with nursing staff is just as important for doulas—if not more so—than with obstetricians and midwives. As Emily put it, “nurses do have a big influence on the birthing environment, and if the nurse is in a bad mood, everyone is in a bad mood.” Consequently, the doulas in this study had much to say about their experiences working with nurses at the births they had attended.

Although doulas do not provide direct medical care, aspects of the emotional support they do provide in some ways overlaps with encouragement, advice, and emotional support typically expected of nurses. In some cases, doulas in this study reported that they were able to work together with nursing staff in ways that made the relative skills and techniques of nurse and doula complement each other in a synergistic way. In other cases, doulas shared stories of power struggles, tension, resentment, or outright animosity. Melissa spoke at length about her efforts to simultaneously encourage a collaborative atmosphere with nursing staff while also distinguishing herself as a different kind of support person. One such strategy was by intentionally dressing differently than nursing staff:

I personally don't, I don't wear scrubs, because I don't want to ever be mistaken for a nurse, and I don't want them to feel like I'm trying to adopt their uniform. [...] I work really hard to by my dress define myself as other.

For Melissa, avoiding typical markers of nurse identity such as wearing scrubs served a twofold purpose. By presenting herself differently, she was able to both show her respect for the role of nurses through an intentional decision to not co-opt their uniform, while at the same time projecting an image of herself as a different type of professional presence in the birthing room.

Lisa observed a wide range of variation in how different nurses responded to her presence in the labor room:

Some are like, “Hallelujah, great, let’s all work together,” and some have had negative experiences [with other doulas] and you have to work really hard... I kill them with kindness. I want it to be more positive for them to work with [me].

In cases where nurses were less keen on a doula’s presence and participation in the birth, Lisa worked hard to be overtly friendly, accommodating, and helpful. Her response to situations where nurses were less than enthused to work with a doula echoed the approach of all the other doulas. When faced with a wary or even hostile member of hospital staff, be it a nurse, obstetrician, or midwife, the predominant strategy for managing the situation was to make a concerted effort to appear respectful, cheerful, and appreciative in the presence of care providers.

At least among this group of professionals, there is a clear sense that making the effort to build positive relationships and dispel tension between doulas and hospital staff lies squarely on the shoulders of the doula. Emily expanded on the urge to “tend and befriend” described by Lisa and other doulas in the study, and even described how she would take on some of the more menial nursing duties to lighten the hospital staff’s load and show appreciation for their work and time:

Interviewer: What is your personal approach to working with hospital staff? And that could be nurses, midwives, doctors, anyone that you come into contact with.

Emily: Try to make friends [*laughs*]. Yeah, I try to be as friendly as possible, respect their space, respect their expertise, they know a lot of things that I don't. I try to respect their experience and draw them into the doula work if they're interested, and if they're not interested in doing emotional [support or] position changes, [or] partner support, then I try to reduce their load of work that they need to do. Um, so sometimes, you know, I'll change the bed while they are getting the mom up after the baby is born. You know, they change the sheets and stuff, so I'll do that for them so they don't need to.

Although changing sheets is by no means an expected part of a doula's role, Emily saw taking on some of the non-medical and time-consuming responsibilities of nursing staff as a way of improving her relationships with them. From her perspective, these efforts seem to pay off. When asked about how hospital staff typically respond to her presence as she enters the space of a hospital labor room, Emily reported:

Well, I feel like I'm almost on a friend of a friend, um, relationship with a lot of the nurses, especially at Saint Margaret's. So it's like, "Oh, hi! How are you doing?" You know, like, "How are your kids?" That kind of thing.

Emily's positive rapport with nurses working in at least one area hospital suggests that efforts doulas put forth to make themselves appear amiable to nursing staff can certainly turn out to be worthwhile.

While every doula in the study spoke to the importance of building positive relationships and collaborating with nursing staff whenever possible, Emily by far focused the most on the influence of nurses in the labor room and her experiences trying to foster a sense of teamwork with them. When asked to describe a time that she felt she had worked particularly well with hospital staff in a way that resulted in a more positive

outcome for her client, Emily chose to share a story which prominently featured a particularly enthusiastic and open nurse:

...the nurse was just so happy, and just so ready to be there. [...] They were playing Johnny Cash and the nurse knew all the lyrics and she was singing and dancing in the room, and her energy I think really inspired the mom to keep on going even though she was exhausted. [...] I think just the nurse's relationship [made a difference]. You know, we were chatting and talking about last names and stuff. Just meeting each other on a very personal level. And I think that, well, depending on the environment, but I think that if the people in the room have low stress it definitely influences the mom.

In this situation, Emily felt that she was able to make a personal connection with the nurse which facilitated a better sense of teamwork and collaboration as they worked toward their mutual goal of helping Emily's client have a healthy and satisfying birth experience. All of that said, Emily did not report that her experiences with nursing staff had been universally positive. She expressed a concern that some nurses may see a doula's presence as a sign that she can sit back and take less of an active role in a given patient's labor, even though doulas lack many of the critical professional skills and knowledge that nurses bring to the bedside:

...I wonder sometimes if medical staff sees doulas as kind of taking the best part away from their job, you know, like the emotional support. Other nurses see it as a way for them to not have to work at all, so they go and do paperwork or whatever else they do at the nurse's station.

Emily described multiple scenarios she had experienced where nursing staff failed to spend as much time in the labor room with her clients as was necessary, seemingly because she was there to provide care instead. In these situations, particularly at the beginning of her career as a doula, Emily reported feelings of uncertainty and worried that her patients were not receiving the care they needed or deserved. She expressed a desire for nurses as well as midwives and doctors to receive more education on the role of

a doula in the labor room, specifically their nature as non-medical professionals, because, as she put it, “I think sometimes they think we know more than we do.”

While all of the doulas acknowledged that some nurses were more open and friendly to their presence than others, Allison described a somewhat unique case where the same nurse who had once been collaborative acted very differently at a later birth with a different client:

[At] one birth in particular where [I had] with the nurse before, I [knew] her to be really awesome, she’s really good at her job, and she’s energetic and wonderful. She maybe has a problem checking her ego at the door, because I think she and I were kind of having, just a strange power dynamic in the room. I was taking away the part of her job that made her feel important and made her feel nurturing so at that point I [told] myself... “Well, I’m not gonna back down and stop working because this person doesn’t want me to be [here].”

Allison described how in this particular situation, the nurse seemed to almost be going out of her way to contradict everything she said, causing Allison to worry that she looked bad in front of her client. After that experience, she described leaving the hospital feeling “hurt and bothered,” although her client later described the experience as extremely positive. Although Allison was pleased that her client was happy with her birth, she still struggled to process the way that the nurse had treated her so differently in comparison to past births where they had worked well together. At a separate point in the interview, Allison offered one potential explanation for some nurses’ wariness of doulas in the labor room:

I have heard nurses say, directly to me, “You just take the best part of our job away from us.”

At least in this particular case, it appears that the nurses in question perceived doulas as a threat to the satisfaction they otherwise received from providing emotional support to their patients. In situations where nurses feel this way, it is easy to imagine how tension

or even resentment could build between nurse and doula, potentially influencing the atmosphere of the labor room and the experience of others present—not least of whom is the laboring mother herself.

Sarah offered yet another set of potential explanations for differing attitudes among nursing staff toward both doulas and laboring women. For her, job satisfaction was a critical factor in whether or not a nurse's presence would ultimately be a positive or negative one in the labor room. Sarah used this knowledge as a way of relating to nurses, presenting her presence in the labor room as a benefit to not just her client, but also to them:

I just say, "I'm the nurse's helper, and I was brought in to make sure that my client's wishes are adhered to when it's okay. Of course we don't get in your way at all." And then also, [I'm] just brought in as an outside person to assist in any way that I can, because, let's face it, nurses are the most under-recognized, underpaid profession in the world. So I can win over a group of nurses with no problem, because then they get a break. They don't have to sit in there for the whole time nonstop, listening to the moaning and the pain and trying to do stuff. They get a break if they want a break.

Sarah also noted that everyday human needs of nurses could also influence their attitude in the labor room, for example, whether they had had the chance to eat recently, or if they were on a particularly long or unpleasant shift. By being conscious of the intensity of nursing care and the lack of recognition that many receive, Sarah felt she was better able to build positive relationships with the nurses she encountered and thereby potentially improve the overall experiences of her clients.

Along with job satisfaction, Sarah speculated that the age of the nurse might have an impact on her style of practice and ability to provide effective emotional support to laboring women:

I feel like what I've found in attending births is that the older the nurse and the longer she's been practicing nursing care, the less likely she is to feel empathetic or sympathetic to a laboring mother. She's seen this hundreds of times and [says], "Oh, you'll be fine," and, "just get on all fours and handle it."

In cases where nurses seemed to display this kind of dismissive attitude, the role of the doula as an empathetic presence and provider of emotional support was made all the more valuable as a contrast to messages from nursing staff which could be perceived as unsympathetic or discouraging.

Every doula cited the importance of building positive relationships with hospital staff, and nurses in particular, as a project requiring effort and investment over time. Lisa described how making good connections with various nurses could lead to a ripple effect throughout the nursing community in the region, since many nurses know and talk to each other about their work:

I think it's just time and experience and, you know, now I'll go into a hospital and even if the nurses initially, um, have a negative thought about doulas, another one of the nurses will say, "Oh, I worked with Lisa at this other hospital, she's great." [...] Whenever I work in a new hospital, I feel uncomfortable until I get the lay of the land, and if I see a nurse that works there that does per diem at other hospitals, I'm always relieved.

In Lisa's experience, a positive relationship with one nurse could therefore lead to similarly positive relationships with many nurses, even across hospital systems. Allison perceived some slight differences in the way she was received as a doula at some hospitals in comparison to others, but overall reported feeling generally "well-received" at all of the place she had attended births so far, as did Melissa.

Given the fact that contact between doulas and nurses is almost always more extensive than contact between doulas and any other member of hospital staff, positive relationships, respect, and collaboration are arguably more important in this area than any

other as doulas attempt to navigate hospital spaces during the course of their work with clients. Whether or not doulas' efforts to work collaboratively—or at the very least coexist—with nursing staff are ultimately successful depends upon a variety of factors that are both in and out of their control. Although numerous articles published in professional nursing journals have advised nurses in maternity care settings to make an effort to build positive relationships and collaborate with doulas, the experiences of the women in this study indicate that many nurses they encounter are not putting these recommendations into practice (Ballen and Fulcher 2006; Gilliland 2002). A better understanding of how nurse-doula relationships work in practice in comparison with how they might work in the ideal world imagined by nursing journals could offer insights that may not only improve working relationships between nurses and doulas, but also maternal experiences and health outcomes for patients/clients.

Doulas with their Clients

Over the course of their time working with a given client, doulas often form strong and intimate relationships with the women who hire them for support during labor. Given the efficiency-oriented, time-crunched nature of modern primary care, most clients will have spent significantly more time talking to their doulas about their pregnancies than with their medical care provider. Through extensive prenatal interviews and support by phone, text, and email before labor begins, doulas and their clients get to know and respect each other in a way that facilitates trust well before the time comes to actually go to the hospital for the birth itself.

These relationships are not inconsequential. If a woman deeply trusts her doula, that doula's opinions and advice will likely carry significant weight and may even impact her decisions about how, where, and with whom she will give birth. This section explores what the doulas in this study shared about their relationships with clients, both broadly in terms of their population and demographics and more specifically regarding their approach to working with individual pregnant and laboring women.

Client Populations

The use of doula support during labor is often associated with white, educated, middle- to upper-class women. Additionally, the mere fact that a woman has a doula implies a certain level of being informed—after all, if a person is going to hire a doula, she must first know that such a service exists, as well as have a certain level of socioeconomic privilege. A search on DoulaMatch.Net for birth doulas in the greater Portland area shows fees ranging from \$175 for a new, inexperienced doula to \$1,200 for a veteran doula. Since doulas are not currently covered by private insurance or public health programs in the state of Maine, these fees must be paid out-of-pocket by clients.

The relative diversity of doulas' client populations is significant because it is highly evident that aspects of identity such as race and class are known variables in health outcomes for different groups of people, both in general and for maternity care specifically (Bridges 2011; Orsi, Margelios-Anast, and Whitman 2009; Marmot 2005). While most doulas in this study identified social justice or advocating for reform in the maternity care system as goals for either their own practice or the profession as a whole, they also lamented the lack of diversity in their client base and the financial

inaccessibility of doula care for women and families who would perhaps benefit most from such services. The need to expand the availability of doula care to more groups of people was a challenge to the profession as a whole acknowledged in some way by all of the doulas in this study.

Three of the doulas, Sarah, Melissa, and Emily, reported serving a predominantly white, educated, middle- to upper-class client population. Emily's description of her typical clientele provides a number of useful insights:

Yeah, I do not have an accurate representation of the birthing world. I was thinking about this, I've never had an overweight woman, you know, as a client before. I've never had anyone overweight, they've all been very health-oriented, so eating organic produce, top-of-the-line products, very much aware of environmental contaminants. Not all, but most have been, upper- to middle-, middle- to upper-class, maybe most are upper-class. And I don't think that there's been a streamlined education level. There have been multiple women with PhDs, a couple of people who never mention any college education, maybe they never had them, I never asked. But all of them are very good at research and self-educating. Which I think is why they find out about doulas in the first place.

Emily's description of her client population includes a number of interesting clues which point to varying aspects of privilege even beyond the obvious economic comfort that they presumably enjoy as members of the middle and upper classes. Health consciousness and good nutrition imply access to fresh produce, as well as the time required to select and prepare healthy foods. The ability and luxury to self-educate about health, body, pregnancy, and birth options that this group of women enjoys is something that Emily credits as a factor in hiring a doula in the first place. Although Emily enjoyed working with her clients, she recognized that their characteristics, resources, and experiences were not representative of the realities faced by many other pregnant women who might benefit from doula care.

Melissa similarly recognized that her client population was not representative of the more rural community where she practiced, and when possible she offered a sliding scale and the option of bartering with clients in order to make her services more accessible. In spite of a genuine desire to help women and families of a lower socioeconomic status, however, she struggled with the financial practicality of such work:

I was just having a conversation with another doula about this last week, and we were both bemoaning the fact that we often feel like the people who need us most are those who are least able to pay, and really wrestling with the business side of this work. It would be wonderful to volunteer all of our time to work with teen parents who could really use the additional support, but yet that doesn't pay the bills. And so how do [I] navigate the fact that the people that can hire me are all upper-middle class with great jobs?

Melissa's dilemma reflects the frustration of many doulas who would like to offer their services to more people in need, but despite having the best of intentions are limited in their ability to do so because they cannot afford the financial sacrifice such work would entail.

Of the two remaining doulas in this study, Lisa reported that she did almost all of her birth work as a pro-bono service for low-income and homeless women, and Allison provided services for clients with a range of socioeconomic statuses. Lisa in particular presents a unique case among the doulas interviewed for this project, and perhaps the doula profession more generally. Her pro-bono work was made possible by the flexibility and security of her day job, which is a relative rarity; because a client could go into labor at any time of day or night, many full-time jobs are incompatible with simultaneously working as a doula. Though her efforts to serve disadvantaged women and families are admirable, Lisa occasionally felt that her work was marginalized or even looked down

upon by certain groups within the national doula community. Lisa stated that she first noticed an institutional lack of emphasis on doula care for low-income and/or otherwise marginalized populations during her first doula training workshop with DONA International, the world's largest doula training and certification organization. Although Lisa felt that she learned a lot of useful information about the physiology of pregnancy and birth, techniques for supporting women, and the business aspects of becoming a doula, guidance on how to work with clients of diverse backgrounds was lacking: "I found DONA was very helpful and very useful in terms of the nuts and bolts. [However,] I don't think they really spoke to medically underserved populations, and that is a big focus for me." She also described a later incident where she was essentially chased out of an online discussion group for doulas because other women disagreed with her commitment to pro-bono work. In their view, Lisa's decision to provide services similar to their own for free devalued their work.

Although none of the other doulas was able to be quite as generous as Lisa was in working with families of lower socioeconomic means, many of them employed a number of strategies for making their services even just a bit more accessible to those who could not pay full price. These included occasionally taking on pro-bono clients, offering a sliding fee scale based on income, the acceptance of bartered goods and services in lieu of cash payment, or a combination of these strategies.

One proposed solution to economic barriers potential clients face in accessing doula care is coverage or reimbursement by private insurance companies and public assistance programs such as Medicaid. As of this writing, only one state, Oregon, allows certified doulas registered as providers within a statewide system the ability to bill to

their state Medicaid agency. Some private insurance companies allow policy holders to pay for doula services out of Health Savings Accounts (HSAs) and Flexible Spending Accounts (FSAs); however, since HSAs and FSAs are far from a universal resource among the privately insured, they do not represent a large-scale solution to covering the cost of doula care for clients who cannot pay out-of-pocket. While general insurance coverage or reimbursement may at first seem like a logical solution to this issue, the inconsistent and decentralized nature of birth doula training and certification presents a significant obstacle to the doula profession receiving recognition from the mainstream insurance industry. To combat this issue, some prominent members of the online doula community have called for a movement toward establishing standards of national certification.

In the midst of a discussion about the prospect of such a national certification system, Melissa, who lives and works primarily in a more rural area than the other doulas in this study, expressed hope that attaining consistent insurance reimbursement for doula care would be helpful in making their services more accessible to women and families of limited means:

I think one of the big impediments to families hiring a doula is the cost. It's just an added expense. And when you're living in a community like this, where each partner is working three jobs simply to keep a roof over their head and pay their light bill, that additional money is a challenge for them. Potentially national certification would actually give us a medical billing code and allow us to bill health insurance, and allow us to be covered by state care. And I think that would be tremendous.

At the same time that Melissa was optimistic about the potential impact of insurance coverage and reimbursement for doula care, however, she was also skeptical about the implications of national certification. She expressed concerns that doula certification in

general requires individuals to compromise some of their professional autonomy in exchange for a credential, limiting certain aspects of their work even if they disagree with the rules set forth by their certifying organization of choice. As an example, she mentioned how DONA International's standards prohibit certified doulas from transporting patients to prenatal appointments or the hospital in their own cars. However, as both Melissa and Lisa pointed out in their interviews, sometimes providing transportation for low-income clients is essential to helping ensure that they receive adequate prenatal care, making it an important aspect of doula care in certain situations.

Insurance and Medicaid coverage of doula care, as well as the standard of national certification that would likely have to be established as a prerequisite, thus present a number of challenges. Establishing national certification will take time, energy, leadership, and resources that do not have an immediately apparent source among the doula community as it currently exists. And even if private insurance companies and state Medicaid programs outside of Oregon begin covering or reimbursing doula services, the rate will likely not cover the full fee of many experienced doulas. For comparison, a 2010 study of the cost of childbirth in the U.S. found that average Medicaid payouts to professional care providers (obstetricians and midwives) for a vaginal birth averaged \$996 (Truven Health Analytics 2013:66). The fees of many experienced doulas, especially those working in urban areas, very often exceed this amount, but it is completely unrealistic to expect that they would be paid more than a primary care provider for their services during a given client's birth. Should insurance and Medicaid coverage for doulas become a reality, doulas with high fees may be unwilling to accept

lower payments from insurers when clients with the means to pay are able to offer more out-of-pocket.

For all of the doulas, regardless of the socioeconomic makeup of their clientele, their client population was overwhelmingly white. Emily noted this fact with discontent:

All are white. Never had anyone of a different ethnicity. Which as someone who has an international background, I'm kind of disappointed in.

Although the demographic makeup of their clientele largely reflects the racial and ethnic makeup of the state of Maine as a whole, growing communities of immigrants and refugees throughout southern Maine do present the possibility of fostering a more diverse client base. When asked about her client population, Allison referenced this possibility directly, but did not seem sure of exactly how to go about accessing such communities without additional support and resources:

...there's a huge refugee population in Portland. And doulas that I'm friends with and that I really love working with, um, we've talked a lot about serving that population, and how it would look to be able to do that, and get grant funding or what have you...

Reaching out to marginalized populations within the community presented a number of potential challenges, not least among them being cost. However, implicit in this well-intentioned desire to reach marginalized groups is an assumption that such services would be seen as necessary or welcome from outsiders. It is possible that such communities already have methods of providing social and emotional support to birthing women in place; further research may do well to investigate the strategies of immigrant and refugee communities in the U.S. with regard to this issue.

Negotiating Client Needs/Desires with Medical Realities

Over the course of their professional careers, doulas attend births in a variety of hospital settings and come into contact with many different care providers throughout the geographic area they serve. Knowledge and experiences from past births provide extensive insights and context that they can use as they interact with future clients who choose the same providers or hospitals. How, when, and whether or not a doula shares this knowledge with a given client is not a clear-cut issue. While some doulas feel strongly that they should not interfere with the provider-patient relationship, others feel that they have a duty to be honest with their clients and be open with their concerns and background knowledge about a given care provider or hospital. Still others walk a middle ground between these two extremes, choosing to share some information in certain circumstances while withholding other details.

To get a sense of how the doulas in this study negotiated sharing or withholding information about a given provider when they knew that a discrepancy existed between their client's wishes and the provider's history with other patients, each doula was asked the following question: "Say you had a client who really wanted a VBAC, but you knew based on past experiences that their care provider was perhaps not the most VBAC-friendly person in the area. How would you navigate that situation in terms of deciding whether or not to share that with your client, and if you do choose to share, what exactly to tell them?" Their answers provide some insights as to how different doulas might respond to this type of situation when it arises in their work.

In general, the doulas in this study tended to lean toward sharing information about a provider when past experience indicated that their style of practice was not in line

with the client's wishes. However, they could all think of situations where doing so would be more or less helpful based on how far along the client was in her pregnancy, the client's personal temperament and personality, and the doula's impression of the what the relationship between the client and her care provider was like. Some doulas described strategies for steering their clients away from a given provider through more indirect means than explicitly stating that they did not think the provider-patient relationship was a good match. Instead, these doulas preferred to help their clients arrive at that conclusion on their own through deliberately focused conversations and targeted questions. Melissa described such an interaction as follows:

“So you chose Dr. Smith. How did you make that choice?” And when she says, “Well, I don't know, he was available.” And I say, “Have you looked at the other physicians in the practice? Have you asked them about their C-section rate?” And really hold out that, you know, if your goal is a VBAC, then what are the steps that we need to take in order for you to achieve that goal that you stated yourself. I'm not giving you that, you yourself have said, “This is the goal I want.”

By encouraging her clients to seek out information about the provider's reputation and history on their own, Melissa found a means to lead her clients to the knowledge she already had of that particular provider without explicitly interjecting her own opinion or past experiences. Without being directly told what to do, her clients were then theoretically equipped to make a decision about whether or not to continue with that particular care provider of their own accord.

Other doulas took a less indirect approach. When asked this question, Sarah, a doula who specializes in supporting clients with high-risk pregnancies, said, “I personally am a very blunt person. That's why people hire me, I've been told.” She specified that

she was blunt not only in telling her clients about the track records of their care providers, but also in letting her clients know when their own desires were unrealistic:

My job is to advocate for your wishes as a birth client. Now if you come to me and you're HIV-positive and you have multiple risk factors and you've had seven cesareans and no cervix and you want a VBAC, at some point I'm gonna sit here and look you in the eye and be like, "That's not going to happen, and we need to get over it, and we need to put a plan in place for you to have the most natural cesarean that you can have." I'm not gonna fight modern medicine on something like that.

For Sarah, then, sharing insider information with her clients extended beyond just informing them of her past experiences and knowledge of various care providers, but also of managing their own expectations about what is and is not attainable based on a person's individual medical situation, the local climate surrounding birth, and hospital policies.

Their extensive knowledge of pregnancy and birth and the risk factors, potential complications, and medical interventions that sometimes go along with those processes provides doulas with a certain level of insight about how realistic their clients' desires are. Although in general most doulas advocate for low-intervention, "natural" birth, they may also recognize when a patient's ideal birth is unlikely, unrealistic, or downright impossible due to the way the maternity care system works or the limitations of the client's own body and health. In these situations, doulas become unlikely allies of the medical model of birth by encouraging their patients to be realistic about what they will be able to accomplish within the realities of the hospital environment where they will birth. Receiving similar messages about what is and is not attainable from both a medical care provider and one's doula may make women more compliant and less likely to protest against certain interventions or limitations on her labor. In these cases, the focus shifts

from trying to fight the system to trying to make the most out of a given situation, even if it is not what a client would prefer to have happen.

Closely tied to this process of managing expectations was the importance of informing clients about the options that they actually do have for influencing their birth experience, such as changing care providers or making preparations for a range of possible birth outcomes. In Sarah's opinion, sharing this information and helping clients to make the best use of it possible was a key part of any doula's role:

If you're seven months into [your pregnancy] and you've had your doula with you the entire time, and you're just now figuring out you're with the wrong provider, I would say your doula hasn't done her job.

Emily advocated for a similar approach to dealing with situations where provider practices and client wishes were clearly at odds. In cases where the client was already past 32 weeks of pregnancy and could no longer change providers, she described adopting a frank attitude toward informing the client that the provider had a tendency to recommend inductions, cesareans, or other interventions, and then working with the client to develop strategies and plans for dealing with those issues if they arose. For clients who were not yet at 32 weeks, she took a direct approach to informing them of her opinion on the provider based on past experiences:

If they're early in [pregnancy], you know, I'll tell them [what I know about the provider]. Because some people hire me, they're like, "I'm with this care provider and I really want a natural birth, and that's why we're hiring a doula." And if they're with one of the providers with the highest intervention level, then I'll tell them. I'll be like, "A doula can only do so much, and the provider has a really big influence as to what happens."

At the same time, Emily acknowledged the importance of not contradicting a care provider in cases where her client had an existing positive relationship with that person:

Before I work with a mom, before I respond to a situation, I ask, “Do you trust your care provider?” And if they trust their care providers, then I support them in whatever needs to happen. So I keep myself out of it, and I try to keep good relationships with the care providers the best I can, because it’s not my job to speak for a doctor, to speak against a doctor’s words, I just need to support the mom on how she feels against [an intervention].

In these situations, sharing information from a critical standpoint and potentially shaking her client’s confidence in her care provider seemed to have the potential to do more harm than good, so Emily opted not to share her knowledge and concerns.

Similarly, Allison shared that she was more inclined to share information directly than withhold it, but also acknowledged that the personality of her client was a factor that might influence how she would approach discussing it with her client:

I think depending on the personality of my client. If I know that they have high anxiety, or depression or something, I may just sort of touch on some details or allude to it, but if I feel really comfortable with someone, and I feel like they’re a direct person, I might directly say, “In my experience, I just want you to know that this person might possibly say things to steer us in a certain direction, so at that moment I might say this to you.” Or, you know, we sometimes come up with plans for things before things happen, if I feel like my client can handle it or would want that kind of pre-planning to happen, if that makes sense.

Due to their often close and trusting relationships with clients, the information that doulas choose to share or withhold can potentially have a significant impact on the choices that their clients make and the subsequent outcome of their pregnancy and birth experience. Given the lack of a standardized code of conduct for these situations among the many doula training organizations which exist and the wide variation between how individual doulas may approach their interactions with clients, understanding how doulas decide whether and when to share information with clients based on their past

experiences sheds light on one of the many ways that their presence can impact maternity care and the birthing experiences of their clients.

Empowerment

Women's empowerment was a theme that came up repeatedly in every interview, though the context and situational understanding of the concept varied somewhat between individual doulas. Although not all doulas used the word "empowerment" specifically, the ways that they discussed the importance of concepts such as choice, agency, autonomy, and involvement on the part of pregnant and laboring women consistently played an important role in how doulas described their work, goals, and perceived impact on the experiences of their clients. In spite of the nuances between how each doula described her work in this particular aspect, a common belief that doula work was a project of empowerment was shared among all of them, and with it an accompanying underlying assumption that the experience of birth itself can and should be empowering for those who experience it.

In many ways, empowerment seemed to be evoked as both a result of achieving the goal of a satisfying birth, as well as an ongoing process or journey toward that goal which began during the prenatal period. During prenatal visits, the doulas in this study described the ways that they tried to encourage a sense of agency in their clients as they made decisions about who their care provider would be and what their hopes and desires were for the type of care they would receive during labor and delivery. By presenting a range of available options and encouraging their clients to think critically about their own wants and needs, Melissa sought to foster a sense of empowerment during these visits:

...I believe strongly that women need to be empowered to make choices, and I feel very strongly that there's lots of options in this area, and just because this is the hospital that is closest to your home doesn't mean it's the best place for you to give birth. And so ideally women will contact me early enough in their pregnancy so that we can have those conversations, and I might say something like, "Within a 20-minute drive of your home, there's four different hospitals. How did you choose that one?" And let her answer that.

From Melissa's standpoint, the key to empowering pregnant women lies in offering them the most complete range of choices possible and then allowing them the space to select the option that most aligns with their own values and desires. However, Melissa also acknowledged that merely having choices was not the same as feeling entitled to make those choices, which is where encouraging a feeling of empowerment in her clients became instrumental. Along with offering up as many options as possible, Melissa emphasized the importance of continually reminding women that they have a say in their care and what happens to their bodies:

That's where I think the education piece comes in, that sort of reminding women that they have options, reminding them that they have choice, reminding them that they don't just need to climb up on an exam table and take their pants off to whoever happens to walk in the room. Really reminding them that they have those options, reminding them that they can choose.

Melissa's approach to empowering her patients in the prenatal period thus included two crucial elements, which she herself clearly identified: "both empowering them to make those choices, and then reminding them of the options that they have available to them." Other doulas echoed the importance of making sure that women are informed of their options and supported in making decisions according to their personal preferences and values throughout the prenatal period.

During the actual process of labor and birth, encouraging empowerment and a sense of agency in clients remained important, though the means of doing so often shifted. Toward the end of pregnancy and after labor begins, presenting the full range of options that was once available becomes less useful as more and more of those options fade away due to time restraints and hospital protocol. Instead, the doula described how they would try to keep their patients as informed as possible about what was happening in the moment, providing context and additional information about the possible ways that labor could progress from each point in time and medical interventions that might be suggested by hospital staff. Emily observed that in her experience, the most important factor in whether or not a woman would recall her birth as an empowering experience was not the material facts of the outcome (that is, whether or not they used pain medicine or had a cesarean section) but rather her level of involvement with the decision-making process and her sense of control over her own body and health. She described one experience in particular which she felt illustrated this idea very well:

So one mom I worked with...it was an induction, ended up with an epidural after three days in labor. Baby was in a bad position because she couldn't move around, and ended with a C-section. But every single choice that she took from the induction to the Pitocin to the epidural to eventually the C-section—she asked for the C-section—she was involved in. She was part of this process. And now I'm in close contact with them, and she says, "Every time I go by the hospital, I get, like, this warm, fuzzy feeling inside." So it's a positive association. So I think that even if doulas aren't there, or doulas are there, just that involvement makes a really big difference in a woman's perception of her birth. [...] I'm not so attached to [the idea that] a successful birth is one that does not have an epidural, that does not end in a C-section, it's really in the perspective of the moms. And so the ways that we can facilitate that positive association is important to me personally as a doula.

In this particular birth story, a sense of empowerment was derived not from achieving a particular kind of birth, but from feeling a sense of ownership and involvement at every

step in the process. In situations where a difficult labor or medical complications require a deviation from a laboring woman's original hopes and preferences for her birth, doulas can play an important role in continuing to help her feel involved in decisions made based on the changing circumstances.

Lisa, a doula who works almost exclusively with low-income clients, described the especially important role that education and empowerment played in her role as a doula for people from a medically underserved segment of society:

...I work with a population that is not used to being listened to as much in the healthcare system. My clients get a lot out of the advocacy where they can make decisions, decisions that they didn't realize they had. So that is super rewarding, because they're not necessarily educated about their choices beforehand.

For Lisa, part of the personal fulfillment she received from serving a low-income population resulted from helping people who had previously felt marginalized or dismissed when interacting with the medical system gain a sense of agency and empowerment. Later in the interview, she shared her belief that the experience of becoming empowered through pregnancy and birth could have effects on clients' lives that extended beyond the birth itself:

And watching some of my clients, how empowered they get if they have a birth where they feel like they made good decisions, and it just makes them better parents, and it's kind of exciting. So it's actually much more exciting when having, say, to work with a family that your expectations are fairly low, and then see them really blossom.

Interestingly, references to female empowerment were not limited to discussions of how doulas related to their clients. A feeling of personal empowerment frequently played into the narratives that these doulas shared about how they found their way into the profession. For some of the doulas who had given birth to children of their own, empowerment was often a theme in their own experiences; for example, Melissa's

“victorious VBAC” and Allison’s positive experience with unassisted home birth. Thus the concept of empowerment and agency for pregnant and laboring women factored strongly in not only the goals and practice of each doula, but also in the personal experiences of those doulas who had previously given birth themselves.

Empowerment, both for their clients and themselves, had a strong presence throughout every interview, and also plays prominently in the discourses that individual doulas and larger certifying organizations use to appeal to potential clients. The difficult thing about empowerment, however, is that while it has the potential to positively influence and even transform individual women and their experiences, its impact can end there. Empowerment is a project of individuals, not whole systems, and while it is possible for individual empowerment to yield community-wide effects, such changes are diffuse and difficult to measure or evaluate. Doulas bring their particular approach to empowerment into the birth experiences of their own clients, but the transformative potential of their actions ends at the threshold of their client’s hospital room; other women down the hall do not benefit in the same way.

The same critique can be made for many other aspects of doula care and themes presented in this chapter. Like empowerment, when doulas facilitate communication between women and their care providers, educate them about their options, and share insider information about various hospitals, obstetricians, midwives, nurses, and their habits and protocols, they work to improve the birth experiences of individuals—not the maternity care system as a whole. Their presence is a response to perceived problems within American maternity care to which they are seen as a solution, but a solution available primarily to women with the means to purchase their services. The unequal

distribution of doula care services and their corresponding benefits is a serious challenge to the potentially transformative power of doula care within the maternity care system as a whole, and merits serious consideration by doulas, certifying organizations, and anyone interested in improving the health outcomes of mothers and their infants.

5. Implications and Conclusions

In the previous chapter, the ways in which doulas experience their work in hospital settings and positively impact the birth experiences of their individual clients was explored through doulas' own words, as well as the trends and realities of the national context of doula care. However, it is critical to keep in mind that the impact of doula care does not begin and end with individual clients. On the contrary, as the number of doulas and women making use of their services continues to increase, birth doulas' influence on the maternity care system as a whole will only continue to grow. Today's doulas have emerged out of a number of specific historical, economic, social, and technological legacies which have changed and affected the way that women give birth from the colonial era to the present. This section is an attempt to connect the knowledge gained from doulas interviewed for this project with the wider national healthcare landscape in which they operate, including the ways that their work and presence impacts hospitals, their clients, and the maternity care system more generally. Additionally, I reflect on doula work, emotional labor, and the commodification of nurturing—their primary role in interacting with clients—and the potential implications of this process.

Benefits to Patients

The benefits of doula care are most apparent at the individual level. This reality has been thoroughly demonstrated by clinical research examining the influence of continuous support for parturient women initiated by the 1970s work of Klaus and Kennell and carried on through the present day (Hodnett et al. 2011; Kozhimannil et al. 2013; Steel et al. 2014; Mottl-Santiago et al. 2008, and others). Doula support

significantly reduces patient requests for pain medication, the rate of medical interventions during labor, and the rate of cesarean section, among other benefits. These realities provide strong evidence that the presence of continuous, skilled social and emotional support for laboring women represents a valuable and fairly low-cost means of improving maternal and infant health outcomes.

In spite of all this potential, the fact remains that only certain types of patients are really benefiting from the merits of doula care. Because doula care is not covered by insurance or public assistance programs such as Medicaid¹², for the most part only women with the means to pay out of pocket can access doula services from a skilled professional. Hiring a doula also requires that an individual be aware of their existence and potential benefits, making education another potential barrier to seeking their services. And finally, while reliable information about the geographic distribution of doulas does not seem to exist, doulas appear to mainly be concentrated in urban and suburban areas, limiting their impact in rural areas.

Benefits to Hospitals

In spite of the fact that doulas are third-party care providers whose approach to birth often stands in opposition to aspects of the medical model, their presence is tolerated in hospital settings throughout Southern Maine and across the country. This simple fact should not be taken for granted. Even if patients desire to have a doula with them in the room, granting access to hospital premises and patient rooms is up to the discretion of the nurses, midwives, and physicians who work there, as well as the hospital

¹² One notable exception to this rule exists in Oregon, where doula services are reimbursable by the state's Medicaid program.

administrators who oversee institutional policy and practice. If they are allowed to provide their particular type of care for laboring women in space that is the territory of other professionals, it seems likely that the system in which they operate as a third party is benefiting in some way from their work. Indeed, this does appear to be the case for hospitals that allow doulas to practice within their walls.

New paradigms and incentives within the American healthcare system have made patient satisfaction a higher priority than it has ever been before. Patients are no longer simply patients, but also consumers of healthcare and customers of the specific hospitals and clinics where they receive health services. When customers demand a certain service or amenity, be it Jacuzzi tubs, Wi-Fi, or birth doulas, it is in the hospital's financial interest to accommodate those desires. Furthermore, providing and allowing for these complementary resources and services does not require hospitals to alter their existing protocols, nor care providers to change their methods of practice. Improving facilities and allowing patient/consumers more leeway in bringing in the social and emotional support of their choice, including doulas, can yield higher patient satisfaction without requiring the system itself to change in any meaningful way.

As was discussed earlier in the previous chapter, one role that doulas take on is that of helping to reconcile their clients' needs and desires with the realities of the hospital setting. Doulas' experience from seeing many hospital births provides them a wealth of knowledge about the trends and protocols in local hospitals and the habits and style of practice among providers throughout the area. Sometimes, by coaching and advising their clients in advance about how to advocate for themselves, doulas are able to make use of this knowledge to help their clients navigate or subvert the system to achieve

birth outcomes that might otherwise have been difficult to attain without additional support. Other times, they support the institution of medicine by informing their clients about what is and is not realistic to expect from a birth experience based on the client's hospital of choice, care provider, and individual risk factors and health status. In these cases, clients are perhaps less likely to complain or push back against interventions because they have already been prepared by their doula, an individual they often trust immensely by the time they go into labor. Thus, in many ways, doula also end up inadvertently supporting hospital policies by educating and preparing their patients for what to expect during a hospital birth.

Doula also benefit hospitals by providing the continuous, one-on-one support that most hospitals simply cannot offer all of their patients. While such care may be assumed to fall under the purview of nursing staff, today's nurses must deal with a variety of conflicting responsibilities that limit the time and energy that they have to offer each individual patient in their care. The presence of a doula makes patients feel more supported and cared for during their labor, and subsequently may increase the overall satisfaction they feel with their hospital birth experience in general. When patients feel supported, cared for, and satisfied, the benefit to the hospital as an institution is clear: Happy patients are less likely to complain and more likely to recommend a given hospital or care provider to their friends, family, and even strangers on the Internet.

It is important to note that all of these benefits to hospitals come at no cost to the institutions themselves. Because patients hire and pay for their doula directly, hospitals benefit from doula's labor and their clients' increased satisfaction free of charge. The economic benefits of doula care to hospitals do not end there, either. Because doula

perform many of the emotional, social, and physical support tasks otherwise expected of nurses, their presence frees up time for hospital staff to carry out other functions including documentation, monitoring, paperwork, and clinical tasks important to the smooth operation of the maternity ward. And as is evidenced by Emily's willingness to change the hospital bed sheets and perform other nonclinical tasks on behalf of her clients' nurses, sometimes doulas directly engage in tasks for which a nurse or aide would otherwise be paid by the institution.

That so many hospitals allow for the presence of doulas in the labor room appears to not simply be a case of benevolence or tolerance on the part of care providers and hospital administrators. On the contrary, care providers, hospitals, and healthcare systems stand to gain concrete benefits from the presence of birth doulas on their maternity floors, even if these benefits are not always seen or acknowledged for what they are.

Within the maternity care system, doulas themselves are thus getting a raw deal in many ways. Their marginal status relative to the institution of medicine makes them guests in the labor room who can technically be asked to leave by staff at any time, a rather precarious position for a professional attempting to carry out their work. Meanwhile, the many benefits and free labor that they provide hospitals goes unrecognized and uncompensated by the institutions they indirectly serve by providing complementary care to patients.

Stratification and Inequality in Maternity Care

While the presence of doula care has the potential to make a significant and positive impact on the birth experiences of the women doulas serve, in some ways the

profession as it currently exists in relation to the wider maternity care system appears to reinforce stratification and inequality. Skilled doulas often charge relatively high out-of-pocket fees that must be covered by clients, and thus remain out of reach for many low-income families. A few volunteer doula programs do exist to make such services more accessible to individuals who cannot afford to hire a doula on their own, but they tend to be based only in urban areas and have limited capacity. The dearth of low-cost or pro-bono services is exacerbated by the reality that for a doula to pursue such work full time, she has to charge enough in fees to support herself. The unpredictability of birth limits individual doulas to taking around 2-3 clients per month; taking on more would increase the risk that two women have labors that overlap. To make a living wage, professional birth doulas relying on the income from their work must charge the few clients they are able to take accordingly.

Serving a disproportionate number of privileged women relative to the total population of American women who move through the maternity care system has potentially far-reaching implications. By improving the birth experiences of relatively well-off, well-educated women, doulas may unintentionally be placating or even de-radicalizing the individuals with the greatest power to change the system through advocacy. An effective doula creates a calm environment for their clients within a hospital room that might otherwise be foreign or uncomfortable, does her best to facilitate communication and constructive relationships between care providers and patients, ensures that her client feels involved and empowered in making decisions regarding her care, and provides extensive one-on-one support. These services, while extremely beneficial for the women who receive them, cushion a select group of patients from the

less ideal realities often faced by low-income and marginalized women when they birth in American hospitals. If middle- and upper-class women with the social capital necessary to influence the system are having enhanced birth experiences thanks to their privately-hired doulas, motivation to push for more systemic changes that would improve birth experiences across the spectra of race and class may consequently be lowered among the very women whose voices are most likely to be heard by institutions and authorities.

The Commodification of Nurture

In her landmark book, *The Managed Heart: Commercialization of Human Feeling*, sociologist Arlie Hochschild introduced the concept of emotional labor, which she defined as “labor [requiring] one to induce or suppress feeling in order to sustain the outward countenance that produces the proper state of mind in others... This kind of labor calls for a coordination of mind and feeling, and it sometimes draws on a source of self that we honor as deep and integral to our individuality” (Hochschild 1983:7). Though Hochschild wrote specifically about flight attendants and debt collectors, the applicability of this concept to an expansive range of other professions is clear and well-established in subsequent studies examining a variety of occupations. The expectation and performance of emotional labor permeates the health professions in particular, and complementary care providers, including doulas, are no exception.

Doulas do carry out some physical labor as they work with clients, but the social and emotional support that they provide is far more central to their role, and represents an intensive form of emotional labor. Doulas encourage their clients to carry on through

long labors even when they are exhausted and hungry themselves, smile and put on a cheerful, collaborative façade even when interacting with medical and nursing staff they do not like or who are hostile to their presence, and maintain a calm, knowledgeable presence in the room even when experiencing worry, sadness, or frustration of their own, constantly moderating their emotions and reactions to ensure that their clients experience a “sense of being cared for in a convivial and safe place” (Hochschild 1983:7).

In reflecting on Hochschild’s work on emotional labor, I am reminded of my interview with Melissa, a doula who worked in a comparatively rural area to others in the study. While all of the doulas were remarkably thoughtful in sharing their perspectives, Melissa in particular had clearly spent time thinking through many of the more philosophical questions underlying her profession. During our discussion about the possible effects insurance coverage would have on the accessibility of doula care, Melissa was overall optimistic, believing that it could be a positive step toward expanding access to doula services to families of more limited socioeconomic means. Still, she had some reservations about what recognition and classification by insurance companies would mean for her work:

...I’m not sure that we can professionalize nurture, and I question that piece. Can you quantify what care and nurture looks like? I’m not sure that you can do that. I’m not sure that’s something you can stick in a box and put a label on and give a scope and sequence for.

In Melissa’s view, and the view of many other doulas and scholars, the business of being a birth doula is that of *nurturing*. By “mothering the mother” doulas support women as they prepare to nurture their own babies, providing care, comfort, and encouragement as they navigate the birth process. As a form of emotional labor—by nature intangible and somewhat invisible—doula care has become a contradictory commodity, at once an

unquantifiable service with measurable benefits. Whether and how the doula profession and other major players in the United States maternity care system, including care providers, hospitals, insurers, and the government, will manage to successfully find a way to organize doula care so that it is both accessible regardless of socioeconomic status but also economically sustainable for practicing doulas themselves is a serious challenge faced by birth doulas within the contemporary American maternity care system.

Concluding Remarks

Much like the nurturing that mothers provide their babies after birth, nurturing of the mother through social and emotional support during childbirth is not a luxury or accessory when it comes to attaining healthy outcomes. Decades of clear, consistent clinical research present us with a consensus opinion that continuous social and emotional support for parturient women yields significant, concrete, and measurable health benefits for women and their infants, from the least to the most privileged members of society. A quotation by Dr. John Kennell, one of the first physicians to conduct clinical trials evaluating the benefits of social and emotional support during childbirth, is often invoked by doulas and certifying organizations to convey the importance and impact of their work: “If a doula were a drug, it would be unethical not to use it” (DONA International 2015). Kennell’s implication is that doulas go unrecognized and undervalued within the maternity care system because they fail to fit within its ruling technocratic imperatives. Doula care is not a drug that can be produced and administered in mass quantities, nor a device or surgical procedure that can be used at will. Doulas

speaking, acting, and participating in the process of giving birth in a way that the system can neither quantify nor control—but nonetheless, their presence matters.

As advocates for the women they serve and a relatively low-cost way to reduce medical costs (through fewer requests for medical interventions such as pain medicine and surgery), doulas have the potential to positively impact the maternity care system in a number of ways. However, their impact will be limited at best and counterproductive at worst for as long as the benefits of their services remain accessible primarily to women of the middle and upper classes only. As of now, doulas represent the latest means by which women can “buy a better birth,” making them part of a long line of stratifying forces including obstetricians, Twilight Sleep, hospital birth in private rooms, and childbirth education, among other amenities and interventions that have come and gone as symbols of “a better birth” throughout the decades. Although doula care in the United States arose from these historical legacies, however, its trajectory and ultimate impact need not follow the same patterns. Still, it is important to keep in mind, as Emily stated in her interview, that “a doula can only do so much.” It is up to not only the doula community, but also their client populations and all other stakeholders in improving maternal and child health to find a way to make doula care the solution—rather than a contributing factor—to the stratified health outcomes and other challenges that currently plague childbirth in the United States.

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