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"An extra layer of pressure to be my best self": Healthcare provider perspectives on how doulas foster accountability and bridge gaps in pregnancy-related care

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A B S T R A C T

Despite the importance of respectful pregnancy care, birthing people experience high rates of mistreatment in clinical settings in the United States. In light of persistent racialized maternal and infant health inequities, doula care is increasingly promoted as an intervention. Limited research has examined healthcare providers' experiences with doulas.

As part of an evaluation of community doula programs in San Francisco, California, we interviewed physicians (n = 11), certified nurse-midwives (n = 7), and nurses (n = 10) who worked in hospitals and clinics where doula clients receive care. Using reflexive thematic analysis, we identified two themes around how providers perceive doulas to affect pregnancy-related care. First, providers described doulas fostering accountability at multiple levels. Providers described how their personal sense of accountability to patients increased in the presence of doulas; at times, this mitigated racism and implicit bias in clinical settings. Additionally, through the partnership between the community doula organization and local hospitals, doulas engaged in bidirectional feedback with providers, creating opportunities for institutional-level accountability. Second, providers perceived doulas to bridge gaps in care for pregnant and birthing people by providing services, such as continuous labor support, that are not realistic for clinicians to provide.

This analysis contributes to the broader literature on doula care by describing mechanisms through which doulas improve pregnancy-related care. Doulas may be critical for birthing people who are most likely to experience mistreatment due to racism and other dimensions of oppression. Future research should explore facilitators and barriers to developing partnerships between clinical sites and doula organizations and the long-term effects of these partnerships on health equity.

1. Background

Despite the impact of high-quality, person-centered maternity care on clinical outcomes and patient experiences, birthing people experience high rates of mistreatment in healthcare settings in the United States (U.S.), which has the highest rate of maternal deaths among high-income countries (Gunja et al., 2022; Vedam et al., 2019; World Health Organization, 2016). Black, Hispanic, Asian, Indigenous, and other women of color experience higher rates of mistreatment (e.g., being shouted at or scolded by a healthcare provider or a violation of physical privacy), particularly in hospital settings (Vedam et al., 2019). Additionally, Black birthing people are more likely than white individuals to experience procedures during perinatal care and vaginal births to which they did not consent (Logan et al., 2022). Women of color, particularly Black and Latinx women, have described being ignored in clinical settings, providers withholding information, and experiencing racism and discrimination while seeking care for pregnancy and birth (Altman et al., 2019; McLemore et al., 2018; Smith et al., 2022). Bias and institutional racism within the healthcare system and beyond also put Black women and their children at higher risk of adverse maternal and infant health outcomes (Dominguez, 2008).

In light of persistent racialized maternal and infant health inequities in the U.S., doula care is increasingly being promoted as an intervention, as it can potentially facilitate improved patient-provider interactions and provide birthing people crucial continuous labor support (Adams & Thomas, 2018; Kozhimannil, Vogelsang, et al., 2016). Doulas are non-clinical birth workers who provide emotional, informational, and physical support to birthing people before, during, and after childbirth.

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There are numerous benefits to doula support, including improved health outcomes for birthing people and infants—such as fewer cesarean sections, birth complications, and preterm births—and increased patient satisfaction (Bohren et al., 2017; Deitrick & Draves, 2008; Falconi et al., 2022; Gruber et al., 2013; Kozhimannil, Hardeman, et al., 2016; Lanning & Klaman, 2019). Doulas may improve healthcare experiences by educating clients about pregnancy and birth procedures, encouraging clients to take an active role in decision making and advocate for themselves, and facilitating communication between birthing people and healthcare providers (Strauss et al., 2015; Thomas et al., 2017; Torres, 2015).

Doulas also bear witness to disrespectful care during childbirth (Morton et al., 2018). Their presence can mitigate, but not eliminate, the impact of obstetric violence and racism (Davis, 2019). Specifically, the presence of a doula can promote respectful care in hospital environments. For example, Mallick et al. (2022) found that women in California with a doula present during hospital-based births reported higher levels of respectful care (e.g., agency over decision making, support, and communication) than those who did not have doula support, with the strongest association among Black and Asian/Pacific Islander women. Among respondents insured by Medicaid, the odds of respectful care were 80% higher among women with doula support than those without.

Doulas fill an important role for birthing people and infants, but access to doula support is limited. Pregnant people can hire private doulas, who they typically pay out-of-pocket for a package of services that meets their needs (e.g., prenatal and postpartum visits, continuous labor support, phone- or text-based communication). Community or community-based doulas typically work with community agencies to provide culturally appropriate, low- or no-cost doula services throughout the perinatal period to people who are more likely to experience mistreatment in medical settings and experience adverse outcomes (Bey et al., 2019). Community doulas also connect clients to resources and make referrals to social support services as needed. A third type of doulas are volunteer doulas, typically based in hospitals, who may not meet their clients until the birth. Hospital-based volunteer doulas attend hospital trainings and must adhere to institutional policies (Beets, 2014; Lanning & Klaman, 2019).

Doulas often operate as outsiders in hierarchical clinical environments with established power dynamics, which can support and/or hinder doulas' attempts to ensure clients' needs are met. For example, power imbalances within clinical environments may limit healthcare professionals' ability to voice concerns about patient safety (Farrell et al., 2021; Umoren et al., 2022), whereas doulas, who typically do not report to hospital providers or administrators, may be uniquely positioned to speak up when necessary. In one study, community-based doulas described intervening on behalf of clients to address discriminatory care (Kett et al., 2022). However, the power structure of the medical system may deter doulas from directly advocating for clients or doing so sparingly (Torres, 2015). In two studies, doulas have described witnessing obstetricians engage in unethical behaviors, such as lying to clients and failing to obtain informed consent (Adams & Curtin-Bowen, 2021; Kett et al., 2022). Although doulas in one study tried to avoid confronting physicians directly to preserve working relationships, some reported speaking up or citing hospital policies when obstetricians infringed on clients' rights (Adams & Curtin-Bowen, 2021).

The support offered by doulas during childbirth is typically not provided by the healthcare system. Physicians are not trained to provide the type of labor support doulas offer clients (Torres, 2015). While midwives are trained to support the physiological processes of labor and childbirth, their focus is on the health and safety of the birthing person and infant (Strauss, 2018). Although nurses support patients during childbirth, they are required to spend most of their time on other tasks (Ballen & Fulcher, 2006). In a qualitative study of physicians, midwives, and nurses in Rhode Island, participants acknowledged that they cannot provide continuous labor support due to clinical responsibilities, whereas doulas can devote their full attention to the needs of clients and their families (Neel et al., 2019). When patients desired a lower intervention birth, partnerships between providers and doulas were especially important. Characteristics of provider-doula partnerships included sharing ideas and expertise, and doulas helping to fill gaps in supportive care.

The limited extant research suggests that physicians and nurses have mixed views of doulas, and midwives are mostly supportive of doula presence (Klein et al., 2009; Neel et al., 2019; Reime et al., 2004). Klein et al. (2009) surveyed Canadian maternity care practitioners—including obstetricians, family physicians, nurses, midwives, and doulas—and found that midwives felt positively about doula support during labor, whereas obstetricians were neutral. Notably, obstetricians held the least positive attitudes about patient preferences and autonomy regarding decision making in birth (Klein et al., 2009). In a survey of labor and delivery nurses and doulas in the U.S. and Canada, nurses with more exposure to doulas and nurses who valued labor support had more positive views of doulas (Roth et al., 2016). Indeed, when Lanning and Klaman (2019) surveyed labor and delivery nurses who had worked with hospital-based volunteer doulas in North Carolina, a majority agreed doulas are important on maternity care teams and all respondents reported positive experiences with doulas. In a scoping review, Lucas and Wright (2019) identified three studies that explored the attitudes of physicians, midwives, and nurses toward doulas. They found that an openness to a team approach may contribute to positive attitudes toward doulas among healthcare providers. In another study, practitioners reported that conflict occurs when doulas are perceived to interfere with clinical decision making, obstruct or delay medical care, or damage practitioner-patient relationships (Neel et al., 2019). Papagni and Buckner (2006) found that conflict arose when doulas questioned clinical providers' nonadherence to birth plans or communicated clients' wishes to hospital staff. In addition to establishing mutual respect between doulas and hospital staff, practitioners in Neel et al. (2019) suggested that hospital staff meeting a doula prior to a patient's birth could facilitate good relationships and communication.

Providers have a critical role in patient experience of care and shaping the environment in which doulas work. However, few U.S. studies have examined healthcare providers' perceptions of how doula presence impacts their work and patient experience (Lucas & Wright, 2019). San Francisco, California is home to several programs that aim to address mistreatment of birthing people and reduce racialized birth inequities, including race equity trainings for healthcare providers and community-based doula programs (Expecting Justice, 2022). In this study we explore providers' experiences with and perceptions of doulas as part of a participatory evaluation of a San Francisco-based community doula organization.

2. Methods

2.1. Case description

SisterWeb San Francisco Community Doula Network (n.d.) is a community-based organization that provides culturally congruent community doula care at no cost to Black, Pacific Islander, and Latina/o/x families in San Francisco, with the hope that SisterWeb clients will feel informed and empowered during their birth journey. SisterWeb's mission is to "dismantle racist healthcare systems, strengthen community resilience, and advance economic justice for birthing families and doulas in San Francisco." To create opportunities for bidirectional feedback between doulas and healthcare providers, SisterWeb developed the Champion Dyad Initiative, which fosters the support of one or two staff "champions" at birth sites, including four hospitals where SisterWeb clients deliver (Gómez et al., 2020). Hospital "champions" partner with SisterWeb staff members to advance quality improvement to ensure that birthing people of color receive fair and equitable treatment during their births and pregnancies. After each SisterWeb client's birth, providers are encouraged to fill out a doula feedback form, and doulas are encouraged to fill out a provider feedback form. Doulas also complete provider

feedback forms as needed throughout clients' pregnancies and during the postpartum period. Champion Dyad Initiative representatives from SisterWeb and birth sites meet monthly to review feedback and discuss SisterWeb clients' care but also communicate outside of meetings. Additionally, Champion Dyad Initiative representatives work together to organize meet-and-greets for SisterWeb doulas and clinical staff, presentations for clinical staff about how to best work with doulas, and trainings for hospital staff on respectful care.

2.2. Reflexivity statement

SisterWeb and university-based researchers have worked in deep partnership since 2018 to conduct process and outcome evaluations of SisterWeb's programs. This collaboration has included co-creation of the research design and study instruments, as well as publications and presentations. SisterWeb team members include MA, AC, MM, each of whom is part of the SisterWeb leadership team, has many years of doula experience, and had no formal experience conducting research prior to this collaboration. Collectively, MA, AC, MM have attended approximately 560 births as doulas. The university-based research team, RR, AN, JA, AJ, CM, AMG, all have academic training in public health. The team includes a graduate student researcher with social work training, study project coordinators with additional training in journalism and public policy, an OB/GYN with clinical research training, and faculty researchers with expertise in health equity and maternal and child health. Six team members have given birth, and two were pregnant during data collection and analysis. All team members are cisgender women, four of whom identify as Black; three as white of European descent (including one with Jewish ancestry); one as Indian American; and one as Vietnamese American. Study project coordinator AN had no relationships with study participants prior to the study and conducted all interviews. Due to the public nature of the partnership and prior data collection for a survey of labor and delivery unit staff (Gómez et al., 2020), participants may have been aware that the research team had a long-established partnership with SisterWeb and therefore hold positive views on doulas. The consent process informed participants of the study purpose: to evaluate the impact of SisterWeb's programs.

2.3. Study design

In 2019, we surveyed labor and delivery unit staff at two hospitals where SisterWeb clients give birth as part of the process evaluation (Gómez et al., 2020). We aimed to provide baseline documentation of attitudes toward doula care in each hospital and point to intervention opportunities within sites. Our sample consisted of 129 respondents who were physicians (25.6%) or nurses (74.4%). Slightly more than half (54.2%) of respondents were white, 10.1% were Black; 10.1% were multiracial; 8.5% were Latinx; 8.5% were Asian; 2.3% were Middle Eastern or North African; 0.8% were Pacific Islander; 3.9% reported another race/ethnicity; and 1.6% did not report their race/ethnicity. Among respondents, experiences working with private, community, and volunteer doulas were common. About 70% of respondents agreed that community doulas can help address implicit bias and discrimination, and 80.5% agreed that community doulas can help reduce health disparities. Most respondents were unsure (49%) or disagreed (22%) that they have better interactions with patients when community doulas are present. However, 61% felt that community doulas' presence at a birth helps foster trust. There were no significant differences in perspectives about doulas by provider type. Additional survey findings, details about the academic-community partnership, and doula and client perspectives on SisterWeb's work are reported elsewhere (Gomez et al., 2021; Gómez et al., 2020; Marshall et al., 2022; Arteaga et al., 2022).

These survey findings informed the subsequent outcome evaluation, which began in 2020. From November 2021 to April 2022, we conducted 28 in-depth interviews with providers who worked at 6 hospitals and clinics where SisterWeb doula clients receive pregnancy-related care and give birth. We recruited interview participants by sending emails with information about the study and participant eligibility via facilities' listservs. Prospective participants took an electronic screening survey used to assess eligibility for participation. Participants were eligible if they (1) were a physician, certified nurse-midwife, or nurse; (2) worked in labor and delivery or provided prenatal or postpartum services at a hospital or clinic where SisterWeb's clients receive care; (3) were at least 18 years old; and (4) were able to complete the interview in English. We purposively invited eligible individuals to participate based on provider type and site to aim for appropriate representation from each group. Given that physicians, certified nurse-midwives, and nurses have different roles on the care team and may have different perspectives on doulas, we aimed to include an equal number of participants from each provider group in our sample. The Committee for the Protection of Human Subjects at the University of California, Berkeley approved all study procedures.

2.4. Data collection and interview guide

Participants reviewed and signed an electronic informed consent form prior to scheduled interviews and, at the beginning of each interview, had the opportunity to ask questions. The second author conducted all interviews via phone or videoconference. We offered participants a $40 Visa gift card as an incentive.

SisterWeb's goals around building relationships with hospitals to facilitate the provision of doula care, a review of the literature conducted before the process evaluation, and findings from the process evaluation, including survey results, informed our initial interview guide (Gómez et al., 2020). We collaboratively developed the interview guide by brainstorming topics during a meeting including SisterWeb leadership (MA, AC, MM) and research team members (AN, AMG, JA, CM). AN and AMG incorporated feedback into subsequent interview guide drafts. The interviews explored participants' experiences with and perceptions of doulas generally and SisterWeb community doulas specifically, racism and implicit bias in pregnancy-related care, and experiences with SisterWeb's programs and the Champion Dyad Initiative.

Interviews lasted an average of 51 min. We recorded the interviews and had them transcribed verbatim. One participant declined to be recorded. AN took detailed notes during this interview, which were included in the analysis; however, we did not use any quotes from this interview.

2.5. Analysis

We used a modified reflexive thematic analysis process to better understand providers' experiences with and perspectives on doulas (Braun & Clarke, 2022). Notably, while Braun and Clarke recommend unstructured, open coding, the collaborative nature of our analysis led us to use a structured codebook, which we developed iteratively to both capture key content areas and emergent topics that we had identified as prospective themes through our early engagement with the data. First, AN and RR familiarized themselves with the data, reviewing all transcripts and listening to the interview recordings, and then developed a codebook. Using Dedoose mixed methods analytic software, AN and RR then coded the same five interviews and wrote reflexive memos about their processes (SocioCultural Research Consultants, 2022). They then discussed applications of codes, noting similarities and differences in interpretation of codes, revised the codebook further and coded the remaining interviews, frequently meeting to discuss reflections about the data and identifying potential themes. AN and RR then each identified themes and met to discuss similarities and differences in their perspectives. RR drafted theme abstracts based on this discussion and then received feedback from AN and AMG. RR then drafted results, integrating feedback from both AN and AMG.

3. Results

Participants' average age was 44 years old (Table 1). Of the 28 participants, 82% were white; 14% were Asian; 11% were Hispanic, Latina, Latinx, or of Spanish origin; and 4% were American Indian or Alaska Native. All but two participants used she/her pronouns. With regard to provider type, 39% were physicians from different specialties (OB/GYN, family medicine, anesthesiology), 36% were nurses, and 25% were certified nurse-midwives.

Participants described prior experiences with private doulas, hospital-based volunteer doulas, and community doulas, including SisterWeb doulas, at their hospitals. Most participants described positive experiences working with doulas and expressed desire for more patients to have access to doula services. Many participants indicated that doulas make their work easier by providing continuous support to clients, which allows participants to focus on clinical tasks and dedicate time to patients who have less support. Though providers held primarily positive views about doulas, we found that, compared to midwives and physicians, nurses tended to be more critical of doulas, particularly nurses who did not believe that racism and implicit bias impact maternal care. When probed about negative experiences with doulas, most participants indicated that they had experienced a rare occasion in which they believed a doula had "overstepped the lines of their scope of practice," either by giving medical advice or impeding care by encouraging clients to follow their birth plan when their provider recommended a change in course. One provider shared her belief about how this issue can lead to tension between doulas and providers, and noted that she has experienced this tension more with private doulas:

> I do feel like private doulas do give a fair amount of medical advice. And there's this feeling like, oh, well, they're not a medical professional or a doctor. So why are they giving advice? Which is really not the right, that's a very kind of stereotypical [view]. I think that's harking back to this idea that doctors are always the experts and should have the final say, which I don't subscribe to that. But early in my new career, I bought into that. I think that sometimes it has felt like with private doulas, it has felt like the birth agenda was actually being driven by the doula rather than the patient.
>
> *- OB/GYN*

Participants discussed the ways that doulas impact providers' work and patients' experiences of care. Below we describe two themes identified in the interviews with providers around the ways that doulas foster accountability and bridge gaps in care of pregnant and birthing people. First, doula presence increased providers' personal sense of accountability toward their patients, as well as increased institutional-level accountability through SisterWeb's Champion Dyad Initiative. Additionally, participants perceived doulas to improve experience of care for pregnant and birthing people by providing services, such as continuous labor support, which clinicians are unable to provide due to limitations of their roles.

3.1. Accountability

Participants described how doula presence increased their personal sense of accountability when interacting with patients. The expectation that they were being observed by doulas led participants to more consciously consider how they communicate with patients and approach care. One participant shared:

> It feels a little bit like I'm being watched by Big Brother. And I know that sounds like it's negative, but I know that there is somebody here who has expertise in respectful, equitable care who is watching me and is, whether they want to or not, making some judgment on my communication, my skills, etc. And so when a doula is present, I actually feel an extra layer of pressure to be my best self in those respects.
>
> *-OB/GYN*

Participants perceived patients utilizing doula care to be more informed about pregnancy and birth than those without, due to their expectations that client education is a key component of doula care and/or because a doula client might inherently be someone who does more research. Importantly, participants noted that this belief impacts the extent to which they communicate details to patients about their care. One participant shared how holding this perspective influences her approach to informed consent, as she expected the presence of a doula meant patients would desire more information:

> I guess, maybe, sometimes, implicitly I would say, I can anticipate that if somebody has done the work to get a doula, that maybe they're

Table 1
Participant characteristics (n = 28).

	n (%)
Race/ethnicity[a]	
American Indian or Alaskan Native	1 (4%)
Asian	4 (14%)
Hispanic, Latina, Latinx, or Spanish origin	3 (11%)
White	23 (82%)
Pronouns[a]	
He/him	1 (4%)
She/her	27 (96%)
They/them	1 (4%)
Age in years, mean (range)	44 (29–60)
Provider type	
Physician	11 (39%)
Anesthesiologist	1 (4%)
Family Medicine Physician	1 (4%)
Hospitalist	1 (4%)
Obstetrician/Gynecologist	5 (18%)
Obstetrician/Gynecologist resident	3 (11%)
Midwife	7 (25%)
Nurse	10 (36%)
Years of practice, mean (range)	
Physician	15 (2–25)
Midwife	12 (5–21)
Nurse	13 (3–30)
Site type[a]	
Hospital	26 (93%)
Clinic	3 (11%)
Sees patients for prenatal appointments	16 (57%)
Sees patients for postpartum appointments	14 (50%)
Average hours per week spent working in the labor and delivery unit	
Less than 10 h	1 (4%)
10–19 h	5 (18%)
20–39 h	14 (50%)
40 h or more	6 (21%)
Does not regularly work in the labor and delivery unit	2 (7%)
Average hours per week spent working in the postpartum unit	
Less than 10 h	14 (50%)
10–19 h	3 (11%)
20–39 h	3 (11%)
40 h or more	1 (4%)
Does not regularly work in the postpartum unit	7 (25%)
Frequency of interactions with doulas	
Often	13 (46%)
Sometimes	15 (54%)
Has ever referred a patient to a doula or community-based doula organization	19 (68%)
Familiar with the Champion Dyad Initiative	6 (21%)

[a] Participants could provide more than one pronoun, racial/ethnic identity, and site type.

somebody who would want more kind of detailed information about every single thing than someone else does. I feel like midwives in our practice in general, but in general, kind of err on the side of a lot of information. And sometimes that's overwhelming to people. But I feel like if somebody has chosen to have a doula there, then they're kind of inherently being like 'more is more' in terms of informed consent. So I guess, maybe, that's one thing that I'm aware of, like OK, I'm going to go through all of the details here. Whereas, maybe, otherwise, I'd like spare them some of the nitty gritty that might be confusing or distracting to people.

- Midwife

Participants indicated that doulas directly advocate for clients and support them to better advocate for themselves, thereby increasing accountability and shifting power dynamics in the patient-provider relationship. One participant described a situation when a doula validated a client's decisions, which increased the client's confidence:

And I felt like the doula did a wonderful job of making sure that … we were fully appreciating all of [the patient's] concerns and where she was at and, also, providing the patient with kind of like the understanding and the reassurance that she needed to make decisions during her pregnancy and during those tenuous moments.

- Midwife

Many participants indicated that doulas advocate for hospital staff to call interpreters to facilitate communication, noting that staff often do not call interpreters on labor and delivery units:

The patient was not English-speaking, and this doula was awesome because everyone who came into the room, she was able to help remind them of that so that we could use a translator and really give this patient really, you know, the care that she deserved.

- Nurse

3.1.1. Mitigating racism and implicit bias in pregnancy-related care

When asked about racism in pregnancy-related care, most participants indicated that they believe institutional racism and implicit bias impact the quality of care provided. One participant shared how implicit bias influences the direction of care—and limits options—provided to patients at her hospital based on providers' assumptions about what patients might want:

If your care provider is not aware that they have implicit bias or hasn't taken the time to do any training on those things, what I've personally seen happen is that they will not offer every option available to that laboring person. So they kind of tailor their care in a way that's like not informed consent, where you get to like have all of these options put in front of you, the risks and the benefits put out in front of all of them, and then the patient gets the right to choose what's best for them. I've seen care providers kind of be like, 'Oh, this seems like what this person would want, so let me offer them this one thing.'

- Midwife

Among those participants who shared the belief that racism and implicit bias do impact quality of care provided to pregnant and birthing people, many noted that identifying racism and bias and holding peers accountable for it is difficult. One participant described how challenging it can be to hold her peers accountable:

But the nurses that have been there for a long time can be just terrible, just awful. And if a nurse doesn't like you, and she's taking care of you, she is going to try to have you get an epidural and get on Pitocin and get a Foley catheter, because then you're on automatic pilot. The nurse really hardly ever has to go in your room. She can just watch you remotely on the monitor at the nurse's station. If you've got an epidural, then you're not going to be in pain. If you've got an epidural, then you have a Foley catheter, so the nurse doesn't have to get you up [to urinate]. So the nurse doesn't have to do any labor support once you are epiduralized and catheterized and on Pitocin. And I think that, you know, there's implicit bias, because nurses are part of the institution that, by virtue of the implicit bias that nursing staff display with patients, that it's institutionalized, and it is accepted. And if you're a nurse who calls it out, like I am, then you get animosity from your little community peer group.

- Nurse

In some cases, doulas may mitigate racism and implicit bias, because as patient advocates, they increase providers' sense of accountability toward their patients. Many participants noted that they especially appreciate doula work with patients who are members of groups that are more likely to experience mistreatment in healthcare settings:

I mean, especially if I have a patient that I feel like I'm particularly worried about this as a more disenfranchised person in the hospital system. Like that I would be worried about the staff not being particularly welcoming to her or disrespectful or kind of dismissive or whatever, not giving them her the optimal care, I feel particularly grateful if there's a doula. Especially if it's like a doula that has a good relationship with the patient. Then I'm like, oh, this is so great to have someone else here that I feel like is an ally and an advocate with this patient. And oftentimes, like better than I would be.

- Midwife

A few participants, all nurses, primarily white, indicated that they do not believe implicit bias or institutional racism impact pregnancy-related care. Notably, most of these nurses also expressed strongly that doulas can negatively impact their work by creating mistrust of the hospital staff and questioning interventions that providers recommend. One such participant shared her perspective on how doula presence can impact her work with patients:

But it's more in a way when we have to, like as the health professionals and nurses, when we have to do something because baby is showing signs of distress, and the doula is trying to block those measures.

- Nurse

Conversely, nearly every provider who indicated that racism and implicit bias do not impact pregnancy-related care also felt that patients who do not speak English would most benefit from doula support. These participants were not the only ones to name not speaking English as a reason for their patients needing a doula. However, they universally indicated that translation was the primary benefit of community doula support specifically, despite language interpretation not being part of the doula role and the availability of interpretation services in their hospitals, an underutilized service that participants report doulas hold them accountable to using.

3.1.2. Institutional-level accountability

The Champion Dyad Initiative is a unique model of partnership that allows for bidirectional feedback between SisterWeb and the sites where SisterWeb clients give birth. Given the nature of power dynamics in healthcare, it is not always feasible for doulas to give direct feedback to providers. Through the Champion Dyad Initiative, SisterWeb doulas have a mechanism to safely share feedback with hospital staff, which helps to increase provider accountability around positive collaboration and clear communication with doulas. A minority of participants (21%) were aware of the Initiative. Those engaged with it expressed that the Initiative created opportunities for provider- and institutional-level

accountability.

A few participants noted that the Champion Dyad Initiative provides an important opportunity for their colleagues to receive feedback around communication with patients and doulas, which sometimes highlighted broader problems with institutional practices and led to institutional change. For example, one participant noted that because of the Initiative, she was able to provide feedback to both an individual nurse and their entire unit about the importance of clear communication and consent, including asking for permission to touch patients when providing breastfeeding support. Similarly, another participant mentioned that the Initiative provided feedback about two patients who were upset about toxicology testing in early pregnancy, which led to identification of a larger issue within their institution around drug testing patients without their consent:

> There's a current issue of a couple of patients [who] got drug tested early in the pregnancy [and] were upset about it, but I did verify that that does get discussed with everyone. Of course, there can be holes in that.
>
> *- OB/GYN*

3.2. Bridging gaps

Another way that participants described doula presence improving care is through bridging gaps in care for pregnant and birthing people, such as providing continuous labor support, establishing a relationship prior to the birth, and creating an environment that supports the client in feeling safe during labor. Doulas are not constrained by managing clinical responsibilities, such as charting or caring for multiple patients simultaneously, which enables them to provide attention to their clients that providers usually cannot. Participants noted that by bridging these gaps, doulas improve quality of care in the context of both prenatal care and birth. For example, while many participants believed that continuous labor support benefits patients, several noted that they are typically unable to provide this type of support due to managing clinical tasks among multiple patients simultaneously. One nurse described her perspective on the challenges of providing continuous labor support due to job-related constraints:

> And a patient who's going natural with no pain medications, it's hard to be present consistently when they're laboring. And so there have been a couple of doulas that I've worked with that just really bridge that gap beautifully. They're able to be with the patient, say the patient is needing some sort of medication, maybe an antibiotic or something. And I'm dealing with pharmacy to get that prescription up, and I'm unable to be there coaching and helping the patient move in different positions.
>
> *- Nurse*

Another provider explained how doula support also improves quality of prenatal care, again, by having more open conversations about feelings around pregnancy, rather than narrowly focusing on the medicalized aspects of prenatal care:

> So it's like I think most pregnant people get very little from prenatal care, as it's done conventionally by doctors. I would not say that about the midwives, I think they do a much better job. So I think it makes it that much more important to have doulas who are like actually engaging in conversations about like how are you feeling about your pregnancy and what are your fears? What are your expectations? What questions do you have?
>
> *- OB/GYN*

In addition to having the ability to augment services typically provided in clinical settings, which frequently lack individualized, interpersonal support, doulas also often establish relationships with their clients prior to their birth. Though volunteer doulas who work within a specific hospital or institution may not meet their clients prior to childbirth, community and private doulas will typically meet clients at least once before the birth. For example, SisterWeb's standard approach to doula care includes three prenatal visits with clients, starting at the 28th week of pregnancy. These meetings allow doulas and clients to build rapport and establish trust prior to attending their birth, which enhances doulas' ability to support their clients during childbirth. In establishing a relationship prior to the birth, doulas provide a sense of continuity that is particularly important in the labor and delivery context, given that prenatal care providers do not always attend the birth. One participant articulated her perception of how this relationship impacts her own experience as a healthcare provider:

> The doula knows the patients better than I do most of the time. And so it allows me to kind of give the information and have them have somebody that they can work through that with, with someone that they already trust and have that established relationship with. And so it definitely makes my job easier.
>
> *- Midwife*

Further, doulas often have the capacity to create an environment that feels safe for their clients while laboring. In some cases, this may mean bringing in a music playlist, essential oils, or twinkle lights so that they can turn off the hospital lights in the room, providing the client with a more comfortable place to have their baby. One participant described her perception of a doula who shifted the physical environment of the labor and delivery room for her client:

> I remember it [the birth] was really special, because the doula didn't just create her own overall energy and presence in the room, but she actually brought twinkle lights and affirmations. And the whole room was transformed into this really safe space for the birthing person who was attempting a VBAC [vaginal birth after cesarean].
>
> *- Midwife*

Another way that participants perceived doulas to bridge gaps in care and create safer spaces for pregnant and birthing people is through culturally congruent or racially concordant community doula care, which may mitigate implicit bias in care. Further, given this congruence, community doulas do not only engage in advocacy that is typical of the doula role, but they also act as a bridge between clients and providers, connecting with their clients in a way that is not possible given that providers often do not share racial and cultural identities with their patients. Many participants noted the benefits of cultural congruence as a particularly important aspect of community doula care, given that their care teams are primarily white:

> And I think, again, I am a white doctor, and patients come in and have a very specific–many of my patients are not white, and so I think the [community] doulas, also the fact that they are often like linguistically and racially concordant, I think that they are going to have an opportunity to connect with my patients in a way that I think is more meaningful.
>
> *- Family Medicine Physician*

4. Discussion

This qualitative study found that doula presence had a positive impact on healthcare providers' experience of providing pregnancy-related care, as well as their perception of patients' experience of care. Doulas shifted power dynamics within the clinical environment by introducing an additional layer of accountability that encouraged participants to provide more thorough, equitable, high-quality care. Through the Champion

Dyad Initiative, a core component of SisterWeb's mission to drive community-oriented change in hospitals, participants used feedback from SisterWeb doulas and clients to improve care and share positive feedback with providers, thereby creating opportunities for provider- and institutional-level accountability. Our findings suggest there are benefits to institutional relationships between community-based doula organizations and hospitals. However, to our knowledge, such arrangements are uncommon.

Additionally, participants valued how doulas bridge gaps in care for pregnant and birthing people by building trust with clients, engaging in conversations about their feelings around pregnancy, and providing continuous labor support. Notably, participants perceived doulas to effectively address these gaps, which has a positive impact on the healthcare team's ability to provide quality care and birthing people's experience of care. This study also found that participants appreciate doula support, especially when their patients are from communities that are more likely to experience mistreatment in healthcare settings. While most participants believed that institutional racism and implicit bias impact the quality of pregnancy-related care, they acknowledged it can be difficult to hold peers accountable.

Our study addresses a gap in research about doulas, as few U.S. studies have examined healthcare providers' perceptions of how doula presence impacts their work and patient experience (Lucas & Wright, 2019). To our knowledge, no study has documented the impact of doula presence on provider accountability from the perspective of healthcare providers. Participants in our study described mostly positive feelings towards doulas; however, compared to other provider types, nurses were more critical of doulas. Further, we found that the nurses who were most critical of doulas indicated that they did not believe racism and implicit bias impact maternal care. Our finding that all types of providers in our study generally held positive views of doulas is aligned with our process evaluation finding that there were no significant differences in opinions about doulas (Gómez et al., 2020). Although researchers have documented perceptions of negative relationships among doulas, nurses, and physicians (Neel et al., 2019; Papagni & Buckner, 2006), our findings add to evidence suggesting provider-doula relationships may be more productive and conducive to improved quality of care for birthing and pregnant people, especially when collaboration is involved (Adams & Curtin-Bowen, 2021; Neel et al., 2019).

A limitation of the study is that this analysis included only providers practicing in San Francisco, an area that may be more welcoming to doulas compared to other geographical locations in the U.S. Given the unique context of San Francisco's programs, citywide efforts to address birth inequities, and the existence of volunteer doula programs at some hospitals where participants worked, providers in our sample may be more open to working with doulas and see them as relevant to advancing equitable birth outcomes compared to other geographies. Notably, SisterWeb generally does not serve clients receiving pregnancy-related care in private practices and does not work in the local hospital that primarily caters to this population. Additionally, participants voluntarily responded to a screening survey, which may have led to including participants who hold more favorable attitudes towards doulas. White providers were overrepresented in our sample compared to our team's baseline survey assessing provider attitudes towards doulas (Gómez et al., 2020), though we recognize that a minority of healthcare providers in the U.S. come from Black, Latinx, and Pacific Islander communities. Recruitment occurred during multiple COVID-19 surges that led to understaffing issues in local hospitals, making it more difficult to conduct outreach and for staff to participate. Finally, throughout interviews, we did not continuously probe around what type of doulas participants were describing, which, in many cases, limits our ability to note differences in doula type. However, given that many interview questions asked about experiences with community doulas, and in some cases, SisterWeb doulas specifically, many of the findings and implications of our study are directly related to the ways that community doulas can impact health equity.

Strengths of this study include representation of providers from different roles in pregnancy-related care who work at hospital and clinic sites where SisterWeb's clients receive services. As part of a long-term academic-community partnership, the research team was able to work with SisterWeb leaders to ensure the interview guide included questions relevant to community doula practice and to integrate learnings from the process evaluation (Gómez et al., 2020). SisterWeb staff also provided practical support for conducting the study, given that they had established relationships with each of the clinical sites where we recruited participants.

Our findings suggest doula presence impacts how providers approach pregnancy-related care, including how they approach informed consent and communicate with patients. Additionally, providers' personal sense of accountability increases when doulas are present and the relationship between SisterWeb and hospital sites fostered institutional-level accountability. Many participants indicated that doulas must advocate for their clients to have language interpreters present when appropriate. Given the low use of interpreters in hospital settings (Tang et al., 2014), particularly in the context of labor and delivery during the COVID-19 pandemic (Le Neveu et al., 2020), such advocacy is essential for informed consent and quality care. As such, doulas may be particularly critical to those pregnant and birthing people who are most likely to experience mistreatment in medical facilities due to racism and other dimensions of oppression (Mallick et al., 2022). However, providers should not rely on doulas for language interpretation, as some participants in our study appeared to suggest.

Doulas help fill persistent gaps in the healthcare system, such as a lack of continuity in care and limited time to provide labor support. Community doulas also play an important role in supporting pregnant and birthing people of color due to their emphasis on providing racially and/or culturally concordant support, which is not always available in medical environments. Future research should explore facilitators and barriers to developing partnerships between clinical sites and doula organizations and the long-term effects of these institutional relationships. Additionally, this study highlights the need for future research to examine the differences in perceptions of doulas held among different types of providers, which may shed light on how to support positive working relationships between providers and doulas. Hospital administrators and providers should find ways to meaningfully collaborate with community doula organizations who serve clients at their sites, as these institutional partnerships can result in changes to the environment that support improved care for all patients, particularly those at greatest risk of adverse birth outcomes. Our findings suggest that these institutional relationships can facilitate positive communication with doulas, thereby improving doula-provider relationships, and promote accountability, which ultimately contributes to improving healthcare quality, including equity in outcomes and in patient experience.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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