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Radical Support: Understanding Doula Work as Resistance to Routinized Violence

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## Acknowledgements

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## Introduction

Doulas should teach women how to speak up for themselves, how to weigh risks and benefits on their own...There's nothing that can take the place of physical presence at the birthing. That's the main thing to me. That's what we have to figure out: how to give emotional and physical comfort to the birthing family. We don't have to come up with every medical answer, that's outside the role. Sometimes you stand there until they want you. Sometimes the proximity needs to be closer, physically. You need to be close by, whispering, so they don't feel alone...A cold wash cloth, a loving voice, and attention to what she may need, are the most important things.

-Renie

She turned to smile at me, her warmth and kindness palpable through the computer screen. We had just finished discussing her perspective on why she believes some physicians and nurses took issue with her having previously worked as a doula when she began training as a Labor and Delivery (L&D) nurse. To Renie, the scope of doula work is very clear: attending to the needs of the birthing person, particularly during labor, rather than knowing medical knowledge and "fighting the dragon of the medical model" (her words). However, during our conversation, the entanglements between meeting the emotional and physical needs of the birthing person, knowing clinical information, and doula support started to emerge. Indeed, in my later conversations with Renie and the other doulas I interviewed, I continued to negotiate between the non-medical role of doulas and the medical consequences of their support.

Through conducting interviews, distributing online surveys, and becoming a trained doula myself, I sought to elucidate the nuances of some of these entanglements between scope, ways of knowing, and support. In this thesis, I explore some of the mechanisms through which I believe doula support is able to render such potent effects on birth experiences, outcomes, and neonatal health. Specifically, I link the trust doulas place in embodied and other forms of knowledge to their ability to navigate the multiple timelines and spaces of labor, which

creates connections between experiential and clinical realities that radically recenters the birthing person's affective and emotional experiences in the hospital space. I then explore how trust in the feelings, experiences, and knowledge of the birthing person is also foundational to the act of support. Drawing upon the theoretical framework of technologies of presence, I suggest a distinction through which to distinguish support from care. Finally, I interrogate how these mechanisms specifically work to resist violence towards Black and other marginalized birthing bodies, and analyze legislative agendas to institutionalize doula work within the frameworks of support and presence that I employ.

In order to illustrate the harms that institutionalization could potentially have on the radical ways of knowing and engaging that doulas employ, I draw upon Pierre Bourdieu's 1991 influential essay, "The Peculiar History of Scientific Reasoning". In this essay, Bourdieu reckons with the social context of scientific knowledge construction, writing that it contains "relations of force, its powers, its struggles and profits, its generic mechanisms such as those that regulate its selection of newcomers..." (Bourdieu 1991, 5). Though I grapple with the consequences of doula organizations as scientific institutions, Bourdieu's recognition of the ways in which scientific institutions compete for cultural, scientific, and economic capital, and the consequences of such competition, are useful in framing the potential for individual doulas to fundamentally challenge the routines and hierarchies that contribute to poor birth experiences and outcomes. Likewise, Bourdieu's essay becomes critical in framing the consequences of further doula institutionalization into hospital and governmental routines in the conclusion.

In the rest of the introduction, I present background information critical for understanding the scope of doula work, its consequences on clinical outcomes, and the Black

maternal health crisis. The history of obstetric racism and medical violence towards Black birthing people is outlined, but this introduction does not present a comprehensive synthesis of the many works on the subject. I present key anthropological works on birth and reproduction that frame past and present understandings of the impact of doula support on birth. I briefly engage with the types of doula certification, current Federal and institutional funding and engagement for doula work, and the birth options available for birthing people in the United States to illustrate the many contexts in which doula support is learned and practiced. Past work on provider perspectives on doula work are explored to better understand the tensions that may emerge in the dynamics of a hospital birth. Similarly, I engage with previous studies about doulas' perspectives on their work to frame my interlocuters' engagement with their work. I close the introduction with a discussion of methodologies, brief descriptions of my interlocuters, and summaries of the chapters to come.

### ***What is a doula?***

Doulas are individuals trained to provide “continuous physical, emotional and informational support to a mother before, during, and shortly after childbirth” according to DONA International, one of the foremost organizations in training doulas in the United States (DONA, 2021). While doulas are expected to understand the physiology of birth, doulas are not medically trained and do not provide medical care, and instead are caretakers of the laboring individual's emotional and physical comfort (Papagni and Buckner 2006). The 2013 *Listening to Mothers Survey* found that 6% of survey respondents were supported by a doula during labor (Declerq et al 2014). While this represents only a small fraction of laboring individuals, more

than a quarter of survey respondents indicated that they would have liked to receive doula support after being informed of their role during labor (Declercq et al 2014). For Black women, this number rose to 39% (Declercq et al 2013).

Continuous support during labor, particularly doula care, has been demonstrated to have significant effects on labor outcomes for both mother and baby. Nommsen-Rivers et al (2009) found that women with doula support during labor were more likely to experience non-instrumental vaginal delivery and timely onset of lactogenesis compared to those without doula support. A 2002 meta-analysis by Sauls found that support during labor has been linked to lower rates of analgesia and anesthesia use for mothers, and fewer infants born with 5-minute Apgar scores less than 7. Support during labor has also been shown to increase maternal satisfaction with their birthing experience and feelings of safety before and during labor (Sauls 2002, Pascali-Bonaro 2003).

Black women and other pregnant individuals at increased risk of poor pregnancy outcomes particularly benefit from doula support during labor. Kozhimannil et al (2014) demonstrated that low-income, racially and ethnically diverse women experienced reduced rates of pre-term birth and Cesarean sections compared to those without doula support. Similarly, Gruber et al (2014) demonstrated that compared to non-doula supported sample of women, a majority-African American sample of doula-supported women were four times less likely to have infants of low-birth weight and were more likely to initiate breastfeeding. Immigrant women who received support during labor were less likely to undergo Cesarean sections and were more satisfied with their labor experience (Dundek et al 2006, Hazard et al 2009).

Pregnant and laboring individuals seek doula support for many reasons. Often-cited reasons for choosing doula support during labor is that medical staff do not provide the expected or desired amount of support. Tumblin and Simkin (2001) found that while expectant mothers thought that the majority of nurses' time would be spent on supporting the mother, less than 10% of nurses' time was specifically dedicated to labor support for the expectant mother. A desire for sympathy and reassurance, along with enhanced communication and decision-making power are some of the many reasons why laboring individuals seek out doula support (Beake et al 2018). Concerns specifically over unnecessary interventions during labor, particularly the high prevalence of Cesarean sections, motivate choosing to be supported by a doula (Papagni and Buckner 2006).

The prevalence and increasing popularity of doula support during pregnancy can be understood, at least in part, as a reaction to the medicalization of pregnancy, which has resulted in the transfer of power and control over pregnancy from the pregnant individual to medical professionals (Neiterman 2013). Medicalization is the process through which nonmedical conditions become understood and co-opted, and responded to through medical means. Pregnancy, which is not a medical *problem*, has been treated as one through the expectation of pregnant individuals to partake in regular prenatal care visits and deliver in a hospital. Once in these medical settings, pregnant bodies and individuals are subjected to various medical technologies and interventions that are often unnecessary and potentially unwanted (Jansen et al 2013, Declerq 2014). The dominance of technology in understanding and responding to pregnancy and birth, the technocratic model of birth, has been argued to value control of what are perceived to be unreliable, flawed pregnant bodies over the natural

process of birth, and thus subordinates pregnant and laboring individuals to medical knowledge, expertise, and practitioners (Davis-Floyd 1994). The hospital environment, which may deprive an individual of the comfort of the calm and familiar, may contribute to a laboring individual's stress during an emotionally and socially significant experience.

Doula support actively works against the medicalized and technocratic models of pregnancy and birth in multiple ways. Firstly, by providing emotional and physical comfort to the pregnant or laboring individual, doulas reject the technocratic view of a body as a machine (DONA 2021, Davis-Floyd 1994). As outlined by DONA in the Birth Doula Standards of Practice, doulas serve as advocates for their clients in clinical and non-clinical settings. Doulas support their clients in planning for their ideal birthing experience, whether that be at home, in a birthing center, or in a hospital, through the creation of a birth plan. According to Davis, "birth planning is an empowering act that seeks to disrupt the medicalization of birthing that tends to diminish women's autonomy" (183). By helping pregnant individuals plan for the type of birth they want, doulas help their clients resist being subject to medical interventions, observation, and control in clinical spaces. For Black clients in particular, birth planning can be a protective measure against the racism and potential violence of obstetric care.

The informational, physical, and psycho-social support that doulas provide to clients has been demonstrated to be understood as forms of advocacy (Dietrick and Draves 2008). Doulas act as advocates for their clients in clinical spaces by capturing space for their clients to make their own decisions regarding potential interventions during labor, mediating relationships between practitioners and the client, and facilitating communication between practitioners and the client (DONA, 2020). This mediation can also be seen as taking place between the client and

the medical system as a whole (Davis 2019, 185). Dietrick and Draves (2008) found that answering clients' questions, communicating with others, and respecting the laboring individual's wishes constituted some aspects of advocacy inherent to doula work. By focusing on providing emotional, informational, and physical support to the pregnant individual, and centering them in the decision-making process regarding their own body, doulas actively push back against medicalization and technocracy in clinical and nonclinical spaces.

### ***The Black Maternal Health Crisis***

Disparities in maternal and infant health outcomes between racial groups have been well-documented: Black pregnant individuals in the U.S. are more than three times more likely than White pregnant individuals to die of pregnancy-related complications, and American Indian and Alaskan Native pregnant individuals are over twice as likely to die of pregnancy-related complications than their white counterparts (cdc.org). Pre-term birth is 52% higher for Black Americans than for White Americans, and non-Hispanic Black infants are over twice as likely to die than White babies (Burris, Lorch, Kirplani et al 2019). These disparities persist across levels of educational attainment, indicating that the complex effects of socioeconomic status on health outcomes do not fully explain the existence of these health disparities (cdc.org). As Hoberman (2014) writes, "The recitation of endless statistics documenting medical disparities depersonalizes the human dimension of what is happening to Black people" (5). Furthermore, the use of statistics distracts us from "the behaviors of doctors and patients" and anonymizes and protects perpetrators of medical racism by shifting the problem of health disparities from individual interactions fully to larger social forces (Hoberman 2014:20). The

human suffering and loss of Black pregnant individuals are not captured in the statistics presented above and are instead represented through ethnographic accounts and community knowledge (Davis 2019).

The racist history of biomedicine, particularly anti-Black racism, is long and complex, and thus will not be detailed in this thesis (see Cooper-Owens 2017, Davis 2019 for more). The legacy of this history, termed the “afterlife of slavery” by Saidiya Hartman (2007), manifests in many aspects and perspectives of and in medical practice in the modern day, with clear linkages to medical and obstetric racism today (Hartman 2007, Hoberman 2014, Davis 2019). The afterlife of slavery can be used to understand the source of, and continued perpetuation, of lies such as the idea that Black people have a higher pain threshold, which has been shown to result in different or inappropriate treatment recommendations (Hoffman et al 2016).

Similarly, the afterlife of slavery explains in part the individualization of differentially poor health outcomes to behaviors of Black individuals. Medical “science”, used to justify chattel slavery, perpetuated the lie that enslaved people were in great health, and thus attributed the “sudden” increase in poor health among Black people to emancipation (Hoberman 2014). Individualization of health problems and behaviors is a critical aspect of biomedical culture, however the hyper-individualization and near complete lack of accountability on behalf of the medical establishment for the creation of racial disparities in health can be understood in the context of medical science during the time of enslavement. Dana-Ain Davis (2019) identifies “diagnostic lapses”, “obstetric hardiness” and the idea of “hardy babies” as legacies of racial science during the time of enslavement that produce racist obstetric outcomes (94). Black women and their bodies have been theorized as being

particularly suited to bear the pain associated with childbirth, ideas that emerged from experimentation on Black women during the time of enslavement (Davis 2019, 96). The racial science of the time of enslavement also produced notions that Black babies have superior fitness and hardiness compared to white babies (Davis 2019, 101). The hardiness of Black bodies in general was a belief that saturated overtly racist anthropology and medicine up to the twentieth century.

Given the popularity of such ideas during the time of enslavement, the hyper-individualization of racial maternal and child health disparities of today can be understood in its historical context. Hoberman (2014) links the myth of Black “supervitality” to the misdiagnoses—or failure to diagnose—on behalf of physicians; the expectation of the bodies of Black mothers to be particularly suited to pregnancy and labor overrides overt or subjective indicators or poor health during clinical encounters (85). Understandings of human bodies, organs, and behaviors have been steeped in racist medicine and anthropology, and the racialization of bodies has led to differential interpretations of patient presentations based on the race of that patient in the past and the present (Hoberman 2014, 69-70). The “race-ing” of certain diseases as either Black or White is key in the history of obstetrics and gynecology, and the diagnostic limitations this imposes alongside the racialized interpretation of Black bodies as hardy contributes to the violent misdiagnoses or lack of diagnoses borne by Black women (Hoberman 2014, 65).

Anecdotal and community knowledge details countless experiences of Black pregnant and laboring individuals in health care settings receiving inadequate care, dismissal of pain and symptoms, disregard for bodily autonomy, coercion, and other experiences of racism. As Davis

writes in *Reproductive Injustice*, “women’s own words are a legitimate source of knowledge production” (23). Community and embodied knowledge, then, are central in understanding experiences of racism and potential ways to disrupt processes that contribute to it. To encompass experiences of obstetric violence that are inextricable from the racist and gendered realities of medical practice, Davis (2019) offers the term “obstetric racism.” Obstetric racism includes “critical lapses in diagnosis; being neglectful, dismissive, or disrespectful; causing pain; and engaging in medical abuse through coercion to perform procedures or performing procedures without consent” (Davis 2019, page 562). These manifestations of the afterlife of slavery can then go on to produce differential outcomes in maternal and infant health based on race. Maternal and infant mortality disparities in general, and obstetric racism specifically, become critical concepts in understanding both the positive impact of doula support for Black and other pregnant and laboring individuals of color. While many medical liberals that seek to understand the causes of racial health disparities fail to address the importance of patient-physician interactions in the creation of these disparities, the impact of doula work on outcomes, particularly for Black laboring individuals, evidences the importance of patient-physician interactions in the construction of these disparities (Hoberman 2014, 14; Gruber et al 2014).

The manifestations of the afterlife of slavery in clinical settings also become important in framing the motivation behind the creation of doula training programs and institutions that center Black and indigenous community knowledge and experiences, and advocacy in their mission ([jamaabirthvillage.org](http://jamaabirthvillage.org), [ancientsongdoulaservices.com](http://ancientsongdoulaservices.com)). According to Davis (2019), Black birth work has always been radical in that it has fundamentally challenged white supremacist

foundations and outcomes of reproductive science during the time of enslavement when sexual violence upon Black women was used as a tool of increasing wealth for slave-owners through forced pregnancies and births. Some Black birth workers today view their work as a continuation of resisting the politics of reproduction and draw a direct line between the injustices during the time of enslavement to birth justice and broader social movements of today (Davis 2019). In these contexts, doula care and birth work become radical acts against not only the technocratic and medical model of pregnancy, but the racism and harm that such models continue to perpetuate.

In my discussion of doula work, its benefits, its practitioners, and biomedical perspectives on its practice, we must not forget that birth work and doula work specifically can be powerful and radical acts against obstetric racism. Though I was unable to interview Black-identifying doulas, I inform my discussion of support and presence being radical tools in resisting violence towards Black bodies with the historical and present-day context of the realities of being pregnant, birthing, and Black in the U.S. This context further highlights the radical nature of and critical need for Black birth workers to support Black birthing people, which I will apply to my discussion of legislative agendas and institutionalization of doula work in the conclusion.

### ***Doulas: Types, Trainings, and Certification***

There are many different types of doulas for not only different stages of one's pregnancy, parenthood, and reproductive life, but for other stages of life as well. Many "birth" doulas typically provide support services during pregnancy and the immediate postpartum

stage as well as during labor and delivery. Doulas may specialize in antepartum work, particularly for pregnancies considered high-risk, and in the postpartum period as well. Additionally, there is increased recognition for the support needed by people who may become pregnant when navigating abortion, fertility treatments such as IVF, and fetal loss or miscarriage (Healthcare Incubator LLC, n.d.). Additionally, end-of-life doulas serve non-medical support roles to a dying person and their family (National Hospice and Palliative Care Organization, 2019). In this thesis, the discussion is limited to doula support typically provided by a birth and postpartum doula, though the ideas I suggest could be extended to other forms of doula work as well.

Many doulas undergo formal training to receive certification in a particular form of doula work, or full-spectrum doula work. The emphasis on training and certification for entry into birth work raises concerns over gatekeeping and professionalism of traditionally community-based work based in generational and ancestral knowledge shared among lay birth workers. Certification can lead to the exclusion of those who do not conform to the values and expectations of certifying institutions, as well as excluding those unable to afford the potentially restrictive costs of training, certification, and practice insurance (Henley 2016, 40-42). That being said, certification can grant a doula a certain level of visibility and legitimacy within the hierarchical structures of biomedicine. This can result in disparities in the types of knowledge and backgrounds represented in doulas active within hospital spaces.

Prominent organizations such as DONA, International Childbirth Education Association (ICEA), Childbirth International, and Childbirth and Postpartum Professional Association (CAPPA) offer doula trainings that can be followed with certification. These organizations have

significant reach and visibility within the doula and medical communities. Other doula organizations and collectives that operate on a more local scale can offer their own training and certification process. Such organizations can include birth justice-centered materials in their trainings, which are typically not included in more mainstream doula training programs, though some are now including some anti-racism and health equity materials into their training (CAPPA, n.d.). Thus, the doula community is a heterogeneous group of birth workers with different educational and experiential backgrounds, skills and areas of practice, and levels of professionalism and acceptability within clinical spaces. This becomes relevant in the conclusion, where I discuss the limitations on types of training and certification that doula institutionalization could pose.

### ***Institutional Support for Doulas***

While the majority of doulas are for private hire, the cost of doula care can be restrictive, especially for low-income and/or socially disadvantaged pregnant individuals for which the benefits of continuous support during labor are significant. In urban areas such as New York City, the average cost of a privately hired doula is upwards of \$1000 (New York City Department of Health and Mental Hygiene 2019). The cost of doula services is typically not reimbursed through private insurance and typically not covered by public insurance such as Medicaid. According to a 2014 report, 88% of New York City residents who had difficulty obtaining doula support cited cost of doula services as a factor in their difficulties (Choices in Childbirth 2014, 4). Only about 400 pregnant individuals in underserved communities of New

York City are able to receive doula support at no cost each year, highlighting the vast disparity between need and access in general.

There have been many responses to the inaccessibility of doula care in underserved communities. Community-based doula collectives offer doula services to low-income individuals or members of underserved communities at no or sliding-scale cost (New York City Department of Health and Mental Hygiene 2019). Additionally, some hospitals and clinics have responded to the need for doula care through the creation of hospital-based doula programs. These hospital-based programs take on many forms: some pair expectant individuals with volunteer doulas during pregnancy and establish continuity of care in this way, while others pair laboring individuals with doulas (Gruber 2013, LIDA, n.d.).

Hospital-based doula programs present a unique opportunity for pregnant or laboring individuals who may not have known about doula care, or have been able to access it, to receive continuous labor support. However, the services and access provided by these programs are limited compared to those of a private doula, such as support or presence during prenatal care appointments, creation of a birth plan, or continuity of care through the prenatal and postnatal period (Dietrick and Draves 2008). Despite the limitations of such programs, their benefit on maternal and infant health outcomes, along with maternal satisfaction, have been demonstrated (Dietrick and Draves 2008, Santiago et al 2008, Hazard et al 2009, Gruber et al 2014). It is important to note that these programs initiated doula care/contact in the prenatal period, though the same doula might not have been present throughout the prenatal period and labor. Evaluations of programs that connect laboring individuals to doulas are limited.

Government-supported or -initiated doula programs may not always be welcome within communities, however. Legacies of government-provided birth workers as an element of larger colonial and oppressive regimes rightfully garners suspicion with regards to new government funded birth-related programming within marginalized communities (Theobald 2019, 44-71). Morton and Clift (2014) point out that, “A client whose care is paid for by public health funding may view her doula as yet another intrusion of the state monitoring her experiences against that of the ‘normative’ mother” (196). Similar concerns about a hospital-provided doula might emerge. Hospital-provided doulas are trained to operate within the institutional space of the hospital, and therefore, though unintentional, replicate the values and goals of that institution. While doulas, whether privately hired or otherwise, are already unable to contradict the medical advice of maternity care providers, hospital-provided doulas may be more deeply integrated within systems of biomedical authoritative knowledge and deference to provider opinion and intervention (Morton and Clift 2014, 134). Thus, while hospital-based doula programs represent a great opportunity to provide emotional support to low-income laboring individuals, wariness of the doula’s adoption into a regular hospital-provided and indoctrinated care team member is heavily considered in this thesis in the context of the mechanisms that make doula support radical.

Medicaid is the primary source of funding for perinatal services for low-income birthing individuals in the United States (Gifford, Walls, and Ranji 2017). All states are required to provide maternity care to eligible individuals (income up to 133% of the Federal poverty line) during the course of pregnancy and until 60 days post-partum. States have significant discretion over what services to fund beyond inpatient and outpatient care (Gifford, Walls,

and Ranji 2017). The Affordable Care Act (ACA) extended Medicaid benefits to all families at or below 138% of the Federal poverty line in states that chose to expand Medicaid benefits (Healthcare.gov n.d.). This resulted in an expansion of maternal care services funded by the 31 states and the District of Columbia that expanded Medicaid under the ACA (Gifford, Walls, and Ranji 2017). While many (three-quarters) of the states covered clinician home visits during the prenatal and postpartum period, less than half covered pregnancy-related education, only three states, Oregon, Minnesota, and New Jersey, cover doula services under Medicaid (Gifford, Walls, and Ranji 2017).

The State of New York launched a Medicaid Doula Pilot Program in Erie County for pregnant individuals in fee-for-service or Medicaid Managed Care. The program covers up to four prenatal appointments, support during labor and delivery, and up to four postpartum appointments for qualifying pregnant individuals (New York State Department of Health 2019). The Department of Health intends to expand the pilot program to include Kings County, which has the same borders as Brooklyn, NY. According to a recent correspondence with the state Doula Pilot Program Office, the Pilot Program will begin to operate in Kings County once a sufficient number of doulas have enrolled in the program (Parkhideh and Eide 2021).

The *By My Side* Birth Support Program operates within Brooklyn to offer free doula services to Black and Hispanic families. The program was a part of Healthy Start Brooklyn, a federally-funded program that sought to improve maternal and infant health (NYC Health, n.d.). A 2017 study found that those enrolled in the program had lower rates of preterm birth and low birthweight birth, while rates of Cesarean sections were unaffected (Thomas, Amman, and Brazier et al, 2017). Healthy Women Healthy Futures is funded by the New York City Council

and is coordinated by Brooklyn Perinatal Network, the Caribbean Women's Health Association, and the Community Health Center of Richmond, a federally-qualified health center. All pregnant people are eligible, however the goal of the program is to fund those at greater risk of negative birth outcomes due to race, language access, income level, or other factors (Bronx Health Link n.d.). As I contend with the institutionalization of doulas under government programs in this thesis, I want to recognize the important work that these programs already do in low-income and communities of color. Rather than criticizing these programs, I seek to critically engage with the ways in which government regulation and institutionalization *can* limit the radical nature of doula work through understanding the mechanisms through which doulas support their clients.

### ***Different Types of Birth Options in the United States***

In the United States, labor is typically attended, and that attendant is very often a biomedical practitioner. The type of attendant, though, varies widely. In the *Listening to Mothers III Survey*, 70% of surveyed participants had their labor attended by an obstetrician. Family physicians attended 6% of labors, and 7% of labors were attended by a physician of unspecified specialty. 10% of births were attended by midwives, and 5% of mothers reported that their primary birth attendant was a nurse, though not a midwife (Declercq et al. 2013, 14). Additionally, the vast majority (98.4%) of birthing people give birth in hospitals, while 0.52% give birth in free standing birth centers, and 0.99% give birth at home (MacDorman and Delcerq 2019). The percentage of pregnant people who choose to give birth out of the hospital has significantly increased over the past decade, with the largest increase

being for non-Hispanic white women (MacDorman and Declerq 2019). Each of these birth settings has its own unique institutional actors.

The hospital birth. Hospital births vary across different hospital systems and states, though there are certain generalizations to be made about hospital births. Typically, a hospital birth is attended by a physician, with various nurses, medical residents, and medical students assisting or being present in the labor room. That being said, CNMs do often attend hospital births. Interventions are readily available, as is the operating room in case of an elective or indicated Caesarian section. Additionally, fetal assessment is most likely to occur via electronic fetal monitoring (National Academies of the Sciences 2020). Despite these similarities, different hospitals are likely to have different C-section and breastfeeding initiation rates, which influence decision-making regarding where to give birth (Declerq et al. 2013, 7). Hospitals are also ranked by their ability to provide specialized care for high-risk pregnancies, being labeled from a Level I, basic care, to a Level IV, regional perinatal health center (National Academies of the Sciences 2020). Additionally, some hospitals have in-hospital “birth centers”. The care these “birth centers” offer vary widely, some offering care only for low-risk pregnancies, while others resemble standard labor-and-delivery rooms with additional options for comfort and pain relief that would not be present in a standard hospital birth (National Academies of the Sciences 2020).

Free-standing Birth Centers. Free-standing birth centers are not attached to any hospital. Typically, these births are attended by a midwife, whether they be a CNM, CPM, or CM. Birth centers usually offer a more home-like environment that encourages non-medical pain relief and comfort methods, such as walking around during labor, using birthing tubs, and

nitrous oxide for pain relief. Typically, those that are considered “low-risk” are able to birth in birthing centers. Care is considered birthing person- and family-centered (National Academies of the Sciences 2020).

Home births. About 85% of home births are planned (MacDorman and Delcerq 2019). These births are typically attended by a midwife, though a minority are attended by either a physician, or not attended at all. People choose to have homebirths for a variety of reasons, including desiring a physiologic birth, disliking the hospital atmosphere, or a lack of a hospital or birthing center in their community (National Academies of the Sciences 2020). Midwives and physicians attending homebirths are equipped with a variety of interventions for parent and baby, including resuscitation equipment, oxygen tanks, and Pitocin.

Doulas are equipped to work across and between all three of these spaces, though are typically not involved in planned freebirths. However, given how common hospital-based births are, understanding how doulas are present and active within that space will be the focus of this thesis. That being said, understanding the different spaces that doulas work in and the transitions that may take place among them will be important for my discussion of types of knowledge used by doulas in Chapter One.

### ***Perspectives on Doula Work***

Hospital-based doula programs also present unique opportunities for interactions and relationship-building between medical practitioners and doulas. The opinions of medical practitioners on doula care have been reportedly mixed (Papagni and Buckner 2006) to

generally positive (Dietrick and Draves 2008, Munoz and Collins 2015). Physician perspectives on doula care are mixed, with descriptions of both positive experiences and conflict with doulas in the labor-and-delivery room. While medical staff felt the advantages of culturally and linguistically competent doulas to support a diverse patient population, physicians also perceived conflict with doulas as well. The negative experiences with doulas in this setting include physicians interpreting doulas as representative of a birth counterculture, doulas delaying care and interventions, and feeling as if doulas paint medical staff as the enemy (Neel et al 2019). While there was some recognition among midwives and physicians that worked in a hospital with a volunteer doula program that medical training in interventional labor techniques may contribute to these animosities, the impact of the presence of doulas in the hospital labor-and-delivery setting is equivocal (Neel et al 2019).

Practitioner perspectives on doula care also depends on the specific types of services and support that the doula renders for their client. A case study of a volunteer abortion doula program found that physicians and nurses generally had a positive perspective on doula care, and supported the promotion of patient-centered care allowed for by the presence of doulas (Chor et al 2018). Practitioners also value the supportive and communicative role that doulas or non-medical support staff adopt when supporting immigrants or individuals with limited English-speaking ability (Dietrick and Draves 2008, Hazard et al 2009). It is clear that practitioners' perspectives on doula support during labor and delivery vary widely. Doulas are seen as a symbol of resistance to biomedicine by some practitioners, yet other physicians, nurses, and midwives appreciate the supportive and communicative capabilities that doulas possess.

A variety of studies have engaged with doulas on the nature of their work, their motivations behind becoming a doula, and how doulas perceive the impact of their work. A theme that emerges from the literature is that doulas view their supportive role as empowering (Dietrick and Draves 2008). Interestingly, doulas cite each aspect of their work, whether it be emotional, physical, or informational support, as empowering to the birthing individual (Dietrick and Draves 2008). Doulas also recognize the importance of their work in the individual lives of their clients and in the larger public health discourse regarding maternal and infant health outcomes. Richards and Lanning (2019) found that volunteer doulas supporting individuals undergoing Cesarean section valued their role in promoting positive experiences for each client they serve and supporting earlier initiation of skin-to-skin contact and breastfeeding.

The significance of birth as a stressful but transformative event in the life of an expectant individual underlies the philosophy and practice of doula support during the prenatal, birth, and postpartum period (Dietrick and Draves 2008, Richards and Lanning 2019). Thus, doulas seem focused on facilitating this transformation in a person-centered manner as likely the only person in a birthing space specifically meeting the non-medical needs of the expectant individual (Spiby et al 2015). Indeed, as I will discuss in Chapter One, it is this recognition of the deeply impactful and transformative nature of birth facilitates is radical because of how it challenges dehumanizing biomedical care for pregnant bodies, particularly for Black and other marginalized bodies. This thesis builds on a body of literature that situates doulas within the liminality of pregnancy and birth, and further explores their role in mediating

such experiences by connecting doula support to different ways of knowing and engaging with birthing people and maternity care providers.

### ***Methodology***

The experiences and wisdom that I share in this thesis are not my own. Over the course of three months, I had the incredible opportunity to speak with and learn from an inspiring group of doulas and birth workers. Conducting ethnographic field work during the COVID-19 pandemic was certainly a challenge, however all of the individuals I interviewed and interacted with during my doula training were so gracious and generous with their time despite the burden placed on them by the pandemic. I am so grateful to everyone who volunteered their time to connect me to other birth workers and to speak to me about their experiences and insights.

This project was approved by the Washington University in St. Louis institutional review board. All data that is presented in this thesis is anonymized. While the insights, stories, and experiences shared reflect the real interview data I collected, the names and some demographic details about the participants and the stories they shared have been altered to protect their privacy.

To recruit participants and gain a general understanding of the opinions of doulas on support, racism in medicine, and working with practitioners, I distributed an online survey through two channels. A link to the survey was sent to an email list for a prominent doula-certifying organization in Long Island, New York. A link to the survey was also posted in a regional doula interest group on Facebook. 13 doulas filled out the survey, answering questions

about their perceived ability to support clients, their relationship with medical providers amongst other topics. Participants were then able to indicate if they were interested in being contacted for a follow-up interview. Out of 13 respondents, six indicated that they were interested in being interviewed. Out of those six, four responded to my request and were ultimately interviewed. While the results of the survey are not explicitly shared in this thesis, the data helped inform my understanding of the opinions of doulas on racial disparities in maternal care, their role in improving birth outcomes, and other important topics. This data guided my interview questions and the interpretation of interview data.

I also sought to understand the opinions of maternal care providers on the role of doulas in clinical spaces and promoting better birth outcomes. To do so, I distributed a survey designed for providers to express their opinions regarding the impact of doulas on their ability to render care and work effectively in a clinical setting. This online survey was distributed to maternal care providers at two large teaching hospitals on Long Island, New York. These two teaching hospitals previously housed volunteer birth doula programs. 25 individuals responded to the survey. 16 were midwives and eight were labor and delivery nurses. The vast majority of the respondent were white. Four respondents indicated that they were interested in being contacted for a follow-up interview. One midwife responded to my request. The results of this survey were valuable in framing my understanding of the impact of doulas on relational networks within a clinical space, despite the fact that such data is not explicitly shared in this thesis.

I underwent a multi-week full-spectrum doula training at a prominent birth justice-centered doula organization. This training was a virtual, synchronous affair that met multiple

times a week. I was in a cohort of about 50 other trainees from all across the country, though most were centered around the New York Metro area. The input of the trainees contributed richly to the experience of the doula training, though none of their comments are included in this thesis due to my inability to gain informed consent from them. Our training consisted of synchronous lessons, guest speaker talks about a variety of subjects ranging from abortion care to the human rights framework, and weekly homework assignments on related or new topics. In addition to our virtual sessions, two in-person sessions were held in order to demonstrate comfort measures that doulas can use. I unfortunately was unable to attend either of these sessions. Brief ethnographic accounts from my doula training experience are included in this thesis. The name of the trainer was altered for the purpose of this thesis, and the name of the training and certifying organization not shared in order to protect the privacy and intellectual property of the organization. For those interested in pursuing a birth justice-oriented doula training experience, a list of resources will be shared at the end of this thesis.

I conducted interviews with four doulas and one midwife. With two of the doulas, I conducted a follow-up interview. These interviews lasted from 20 minutes to over an hour and were conducted over HIPPA Zoom or via phone. For Zoom interviews, an auto-transcript was generated which I then went through and corrected. For phone interviews, I recreated our conversations to the best of my ability based on my detailed notes. All interview participants' names were anonymized during the analysis and narrativizing processes. Interview questions were inspired by participants' responses to the survey and were also based in the methods used by Neel et al. 2019. Dr. Kira Neel kindly advised me on how to best approach asking

providers to share their experiences working with doulas. The data collected from these interviews formed the bulk of this thesis.

### ***The Sample***

The doulas surveyed and interviewed in this study were for the most part White, which reflects the general lack of diversity in the doula community at large (Lantz et al 2003). Out of the 13 doulas I surveyed, one self-identified as “mixed Black/White/Indian”, and another as “White/Native American.” Additionally, the vast majority of the doulas surveyed either finished their undergraduate education or pursued advanced degrees. This sample highlights the racial, economic, and educational privilege of many doulas, which is important to consider when understanding the role of doulas in addressing the Black maternal health crisis. I have tried to supplement these voices with those that I learned from in my doula training and from the literature. Likewise, only one of the 25 providers that I surveyed identified as non-white, specifically as Black. The small number of interviews conducted and the lack of ethnic or educational diversity in my sample limits the applicability of my findings to the broader doula community, particularly community-based doulas. That being said, I believe in the importance of the trends and ideas that I learned from these doulas. Likewise, it is important to frame the ways in which doulas can address the Black maternal health crisis within the general lack of racial/ethnic diversity among the doula community.

### The Interlocuters

**Renie.** Renie, the woman I introduced earlier, is a White, midwestern woman with over 20 years of experience as a doula. She has experience working in the Midwest as a private doula running her own business, and in the South as a volunteer doula and hospital-based lactation counselor. Renie also sought training to become a nurse-midwife, and although that did not work out, she does have experience as a labor-and-delivery nurse as well. Despite her many other careers and experiences, Renie told me off the bat during our first interview that she was “once a doula, always a doula.” Renie’s extensive experience as a doula in multiple settings contributes significantly to my discussion of intuitive knowledge, institutional knowledge, and support in Chapters One and Two.

**Joy:** Joy is a mixed-race, White-passing middle-aged woman who hails from a Midwestern metropolitan area. Joy is new to doula work: the experience of a family member birthing during the COVID-19 pandemic inspired her to support birthing people through doula work. Beforehand, Joy cared for birthing people as a labor-and-delivery nurse for over 15 years. “Mommies and babies were always a passion of mine,” she told me when she explained her background. This transition from nursing to doula work provide such unique insights into how institutional knowledge can inform support, and tensions between care and support.

**Lorie:** Lorie is a middle-aged White woman who works as a privately hired doula, a volunteer at a crisis reproductive health center, and at a nonprofit. Working between these boundaries has

provided Lorie with a perspective into how clients of different backgrounds are treated differently in the hospital setting, informing my discussion of presence in Chapter Two.

**Diane:** Diane is a young White woman from Long Island. She previously served birthing people who were apart of the adoption process. This experience helped her discover her passion for supporting birthing people, and she entered the doula world. Diane is a member of a large doula organization on Long Island, serving both private-paying clients and those whose support is subsidized through community funds. Diane's background contributes to my discussion of how insurance and class mediate support in the birthing space in Chapter Two.

**Miranda:** Miranda is a young White midwife from Long Island. She is a part of both an outpatient midwife-operated OB/GYN practice and works in labor-and-delivery at a large academic hospital with the ability to supervise the labor of her own patients. Additionally, the hospital that she works at used to have volunteer doulas present on the floor, so she has ample experience working with both privately hired and volunteer doulas. In my conversations with Miranda, I learned from her insights into the power of doula support in mediating the experience of labor from the perspective of a maternity care provider.

### ***Chapter Outline***

Chapter One explores the various ways of knowing that doulas use and leverage in the different spaces that they occupy. I specifically take a look at the importance of doulas being familiar with biomedical and institutional knowledge so that they can navigate hospital births

and enter pre-existing relationships and hierarchies of power in particular ways. Using data from both my interviews and experience being trained as a doula, I connect the utilization of different forms of knowledge to the multiple ways that doulas can show up in medical and non-medical spaces. Ultimately, I draw upon the concept of multiple timelines taking place in the same space to assert how doulas are able to center birthing people in their own birthing experience. Importantly, I highlight the radical challenge to authoritative knowledge and dehumanization that such processes present and connect this to doulas' abilities to practice without being beholden to an institution.

Chapter Two takes a critical look at the concept of support. Support is the foundational philosophy behind doula work, and I identify a few factors that seem to characterize supportive actions. I call upon Rebecca Lester's (2019) idea of technologies of presence to describe how doulas mediate and resist certain forms of perceiving and being present for their clients within relationships of giving and receiving care during a hospital birth. I begin to distinguish care from support and highlight tensions between these related concepts as they are practiced by doulas. Finally, I argue that it is the separation of doulas from medical institutions that allows both support and the utilization of multiple knowledge systems to become radical, impactful ways of interacting with birthing people and medical spaces.

I conclude that support is a radical way of challenging capitalist and institutional routines in a medical system that disproportionately dehumanizes and harms Black and other marginalized birthing bodies. Critically, I enlist Bourdieu's understanding of the social nature of scientific institutions in order to more fully illustrate the power of doula support when not institutionalized—and raise concerns about the consequences of potential institutionalization. I

critically engage with the ways in which institutionalization could threaten both support and knowledge diversity as key tenets of doula practice. I also discuss recent political efforts to address the Black maternal health crisis and the perceived role of doulas in proposed legislative solutions. Brief discussions of Medicaid reimbursement for doulas and adoption of doulas into hospital systems are presented before I engage with the role that doulas can play in medical and legislative discourse surrounding patient-centered care. I highlight the need for *collaboration* and caution against cooptation in this new effort by medical institutions and birth-related medical institutions in particular when shifting the narrative and practices regarding pregnancy-and-birth related care.

## Chapter One

“When you go for that first home visit, you’re not just meeting the client in a place where they’re comfortable.” Leyla, our doula trainer, told us.

*The faces populating my laptop screen listened intently. After a couple weeks of learning from various guest speakers about the role of birth workers in promoting birth justice, the human rights framework in medicine, and the history of obstetrics and gynecology, our cohort had just embarked upon learning the skills and techniques we’d need to practice as full-spectrum doulas.*

“You’re walking around, you’re looking at the bathroom, at the kitchen, thinking, ‘What am I going to do if this person delivers here? How big is the bathtub? Do they have paper towels?’ Because you always need to be prepared.”

In the studies that have demonstrated the power of doula support in improving birth outcomes and experiences, one very clear choice was made in the language used to describe the support provided: non-medical (Kozhimannil et al. 2013). The Doula Association of North America emphasizes the non-medical role of doulas in its scope of practice for birth and postpartum doulas (DONA 2017). If the scope of doula services is limited to non-medical support, then why did Leyla instruct her trainees to view the client’s home as a birthing space? To know what is needed in the case of an unanticipated home birth? Indeed, much of our time in training was devoted towards understanding the anatomy, physiology, and temporality of pregnancy, labor, and the postpartum period. At the same time, in many of my conversations with doulas and in the training itself, doula practice was characterized by a deep connection to intuition, ancestral knowledge, and alternative modalities.

When conducting my interviews, I sought to understand *why* biomedical knowledge was so essential to doula support such that hours were devoted to its learning. I also hoped to further explore the role of non-biomedical ways of knowing in doula practice, and how these

different types of knowledge manifest and are differentially employed in doula work. In this chapter, I explore how the doulas I spoke to use different knowledge systems in order to navigate the multiple spaces, both medical and non-medical, that they operate in. I interrogate how doulas leverage different types of knowledge in medical spaces and examine how those choices reflect the values and hierarchies of the hospital space. I employ Sameena Mulla's idea of multiple temporalities or timelines within one space to frame the power of doula work, identifying that doulas are the primary agents that identify and reconcile divergences between these timelines. Ultimately, I suggest that it is this act of validating, communicating with, and elevating the experiential timeline of labor to clinical recognition that contributes to doula work as a potentially radical act.

Doulas must operate within and between many spaces throughout the course of working with a single client. Despite the officially non-medical role of doulas, the vast majority of births take place in a hospital or other medical settings, so doulas must be able to embody their non-medical role in a medical space and all of the hierarchies and routines that characterize such a space (National Academies of the Sciences 2020). Meeting with the client prenatally and postpartum in their home, attending prenatal visits with a provider in an outpatient center, being present for a birth in a birthing center or a hospital labor and delivery room, and visiting the new parent and child in a postpartum room are just some of the spaces in which a doula could potentially be supporting a client.

Though a doula is a non-medical provider, their clinical and biomedical knowledge seems to be essential to their ability to operate in various settings. Indeed, the vignette introduced at the beginning of this chapter illustrates that Leyla specifically trained us that the

“home visit” or first prenatal consultation with a pregnant person serves more than to just meet them. Doulas must look for what resources the living space does and does not have in case of an unexpected, early, or rapidly progressing labor.

It seems that bridging non-medical and medical spaces becomes an essential task of a doula in serving and supporting their clients. However, the different spaces that doulas move among have vastly different values. Hospital settings and their institutional routines, hierarchies and behavior policing create unfamiliar and unwelcoming environments for the client and potentially the doula. Doulas are not usually trained by hospitals or similar institutions (though there are certainly exceptions to this) and are typically considered outsiders to that institution (Ellman 2020). Despite this, doulas work to situate themselves and their clients within these unfamiliar spaces in meaningful and intentional ways so that they can best provide support, which will be discussed in detail in the following chapter. Being an “outsider” to the hospital as an institution, as I will argue, is not only characteristic of doula work but essential to it. Being external to the naturalized hierarchies and routines of a hospital birth allows doulas to employ multiple ways of knowing to facilitate their movement among and through birthing spaces with intentionality, cognizant of caregiving and receiving as an intersubjective process.

### ***Authoritative Knowledge and Alternative Knowledge Systems***

Biomedical knowledge is an authoritative way of knowing within biomedical spaces. The interpretation and perception of the progression of labor and needs of the birthing person rests in the hands of biomedical practitioners, who have the authority to interpret and make

decisions based on information gathered through external technologies of knowing, such as contraction monitors and vaginal exams assessing cervical dilation (Jordan 1997, 63-65). Jordan's classic work on this topic features a labor in which the laboring individual is told that they cannot push—despite the fact that this person *feel* that they should push—until the physician grants them permission to do so. In these spaces, embodied knowledge becomes an inferior way of knowing through the ways in which it is ignored, and biomedical knowledge is granted the authority and privilege that is associated with a fundamentally exclusive body of knowledge.

Intuition is defined as “the power and faculty of attaining to direct knowledge or cognition without evident rational thought and inference” (Merriam-Webster, n.d). While biomedicine, in principle, is based upon sound scientific reasoning based on the scientific method or other sanctioned ways of producing knowledge, intuition is based upon internal sensations, perhaps mental shortcuts that do not rise to conscious knowledge. Much like embodied knowledge, intuition is not based upon externally perceptible or evident lines of reasoning. Intuition, then, likely carries the same amount of evidential weight within biomedical spaces that embodied knowledge does, ranking it low among the ways of knowing that influence decision-making within a hospital birth. Despite its low value to biomedical practitioners, the doula that I spoke to draw heavily upon intuition in their practice:

I learned to trust the intuitive nature of the female body. I carry over that intuitive, 'Okay, what's going on?' into my practice.

-Joy

You can meld with a birthing person, without background or books or anything.

-Renie

My doula training emphasized “knowing through your body” as a valid way of knowing and practicing as a doula. The feeling of being physically connected to the birthing person is an important source of information in understanding the physical, emotional, and spiritual sensations of the birthing person and being able to provide support based on those sensations. My doula training contended with both biomedical knowledge and other ways of knowing as informing doula practice. Connecting to “ancestral practices” when approaching doula work and working with clients was emphasized: doula work must be informed by connections to our past in terms of our religious, spiritual, cultural, or familial caretaking and supportive practices. Connections between these ancestral ways of knowing emerge through intuition and physical and emotional connection with a birthing person. In the next chapter, I will dive into the connection between intuition and support, however I introduce intuitive practice in this chapter in order to highlight the different knowledge systems operationalized in doula work.

Despite this sincere focus on alternative ways of knowing how to interact with birthing people and bodies, a significant portion of my doula training consisted of learning biomedical terminology and knowledge relating to pregnancy, labor, and healing during the postpartum period. From learning about which placental complications that can require a Cesarean section to discussing the effects of postpartum hormone changes on the mood of a birthing person, our foundational knowledge of support and comfort was intertwined with a biomedical understanding of why certain techniques could be valuable at certain times.

For example, when discussing the change in progesterone levels following the delivery of placenta, our trainer framed the importance of this drop within the context of supporting a client with bipolar disorder, who may be at risk of experiencing mania because of this hormonal

change. Similarly, we learned that understanding that a client with uterine scarring is at increased risk of placental complications like placenta previa will help us better support them as they navigate potentially requiring a Cesarean delivery. Finally, being able to roughly estimate a client's stage of labor based on their contractions can help us best support a client that sought to labor at home for as long as possible before going to the hospital. While doulas are non-medical support people, understanding the foundations of the biomedical perspective of pregnancy and labor seems essential to providing support to the birthing person. As Lorie situates herself when her client is in labor, she told me that "check[ing] out the contraction monitor" immediately after checking in with the client helps her "get a sense for where things are going." Both intuitive and biomedical knowledge represent important ways of interacting with birthing people and the birthing space. However, claims to biomedical or biomedically useful knowledge can play an important role in institutional construction of doulas as legitimate actors within biomedical settings.

### ***The Importance of Knowing: Leveraging Different Types of Knowledge in Clinical Spaces***

I know they need to lay on their back for 20 minutes, and then we can move into other positions and so forth. But the epidural is medical, you know, [the nurses] are having to look after that. Usually, because we always have to step out of the room for an epidural and then come back in. So in that time I'm like 'so is it okay if we go into like, move into different positions and use the peanut ball after the 20 minutes that she's laying here.' Just kind of giving them a voice in the room, so it's not like we're doing our own rodeo here.

-Diane

Diane, though a non-medical provider, is clearly familiar with the biomedical and institutional routines of caregiving in a hospital space as she navigates supporting a client that is receiving an epidural. How do doulas operationalize biomedical knowledge in order to better

support clients and navigate potentially unfamiliar or hostile biomedical spaces? I argue that biomedical knowledge is a predominant way in which doulas can leverage their power and support clients in the interpersonal world of a hospital birth. Often, doulas use biomedical knowledge to strategically interact with medical providers in that space, easing some tension that may result from an “outsider” that represents alternative values that may be interpreted as challenges to the cultural authority of biomedicine. Within these fragile alliances, doulas can find extra room to support their clients. Diane believes that the rift between providers and doulas is manufactured. “We should all be on the birthing person’s team,” Diane told me, “We all have our lanes to stay in, but we are all here to support the birthing person.” There may be debate over what defines the boundaries of a doula’s “lane,” however, a positive, respectful relationship must be maintained with the various providers present in the L&D room.

Oftentimes, biomedical and institutional knowledge lubricates these doula-provider relationships. Doulas can leverage their biomedical knowledge to strategically insert themselves in such relationships to appease the authority of medical providers by posing no detectable challenge to such authority in such a fashion that they are able to support clients. Consider how Diane strategically employs her biomedical and institutional knowledge about the procedure of an epidural. Diane is clearly familiar with the facts surrounding how an epidural must be placed, and what that means for client comfort. She makes that known within her relationships with the nurses, sharing that common understanding and respect for the nurses’ duty in placing an epidural, and the epidural itself. By gracefully gesturing to her biomedical knowledge and respecting the institutional routine of epidural administration, Diane mediates how she is present within the nurse-doula relationship and the birthing space. She situates the nurses as

authoritative figures in that space: the epidural placement and need for the birthing person to be still take priority over the comfort measures she sought to provide. Thus, the nurses are less likely to view Diane as a threat to their authority, and she is more able to provide different forms of support to her client.

Lorie similarly uses her different forms of knowledge to build a team with nurses and maintain a positive relationship. She described herself as nonconfrontational, but regularly confronted the institutional routine of labor by working within pre-existing hierarchies of authority in a hospital birth. In a situation where nurses described one of Lorie's clients as "terrible" at pushing, Lorie recognized an opportunity to "join [the nurses] in a solution." She always tries to find common ground with providers, she told me. For Lorie, her understanding of physiologic and unmedicated birth, which can be considered alternative to the knowledge and routines utilized in a hospital setting, becomes one way in which she inserts herself into the team of providers:

"They're so used to, 'Get the epidural. Lay in bed. And wake up when you get to 10 centimeters.' They're not going to think of all the options I suggest. So when I say, 'Hey, can we get a birthing ball,' 'Remember to walk,' 'Can we get in the shower...'" Lorie emulated the nurses nodding. "'You can do that.' But they probably would not, you know, thought of all of those things. They're either just too busy or it's not in their routine.

Recognizing how institutional routines may limit the types of care that may be provided, Lorie gently uses her alternative knowledge to guide nurses through pain management for unmedicated clients. While Lorie may not be leveraging biomedical knowledge to mediate her presence and that of the providers, her understanding of authority of position and knowledge in clinical spaces likely diffuses some tension and creates more positive relationships between her and the nursing staff: "I definitely defer to the nurses and medical professionals. I definitely

try to keep them as the professional.” She also told me that “The nurses are glad [she’s] there” when a birthing person attempts an unmedicated birth due to the general lack of experience of nurses in caring for birthing people not undergoing routinized labor.

The disparity in experience of supporting unmedicated births between her and the nurses may have shifted the nature of the birthing space. Though the birth was still taking place in a clinical setting, routinized obstetric practices were not being employed. This could create more space for the importance of alternative knowledge than would typically be present in a hospital birth. Recognizing this opportunity, Lorie is able to both support her clients and assume a position of relative practical authority while respecting the nominal and clinical authority of providers. Lorie’s ability to support her unmedicated clients in this fashion depends on her being an outsider to the caregiving networks and hierarchies of the hospital space. Her alternative knowledge regarding pain management during birth and ability to critically reflect upon the routines and hierarchies of the hospital space allows her to both build positive working relationships with nurses and create better birthing experiences for her clients.

Institutional and biomedical knowledge also grants doulas greater authority in their advocacy ability. Consider an instance in which Joy intervened when a resident informed her client that their fetus was in distress and that an emergency C-section must be performed due to an observation he made on the monitor of the fetus:

What he saw monetarily was something that had happened the entire day. If [the birthing person] laid on one of her sides for too long, the baby had a deceleration of the heart rate. Well how do you fix that? You turn her to the other side.

While she knew the reason as to why the fetus was not in distress, this experiential knowledge was not leveraged with the resident. She instead told the resident that an internal

fetal monitor should be used to assess if a fetus was truly in distress. Joy told me, “He kind of stepped back a bit, like ‘Wow, I wasn’t expecting that.’”

Leveraging biomedical knowledge when confronting a biomedical provider, particularly a physician, strengthened Joy’s position within the space’s hierarchy of authority. Similarly, Joy suggested to the resident to wake the attending physician, which demonstrated to the resident that she is familiar with the institutional hierarchies within a hospital. Once again, the authority of the resident was threatened by Joy using her institutional knowledge. The source of such knowledge, for Joy, is likely her training and experience as an L&D nurse. Though she was working as a doula in this setting, the skills, knowledge, and experience she was able to gain through her career in biomedicine served to strengthen her position of authority. However, without being an outsider to these hierarchies, her ability to directly challenge a superior would likely have been threatened. Thus, biomedical and institutional knowledge can serve to both facilitate smoother doula-provider relations or challenge the potential violence of hierarchy depending on the needs of their clients. Regardless, doulas are savvy agents who strategically employ their multiple knowledge bases to support clients through both meshing with or challenging hierarchical knowledge structures in a hospital setting.

Renie often serves “high risk clients,” who she believed sought her out because of both her medical background and many years of experience:

The moms or couples like me because I’ve seen a lot of things, a lot of problems. The woman has thick, inverted nipples that don’t come out. Problems. She’s had a breast reduction. But these are things that your little nurse or mommy have never come across.

While to her, the knowledge they valued the most was her years of experience as a doula, her comfort with biomedical settings, language, procedures, and practitioners played an

equally important role. Her many years of experience as a doula and lactation counselor inform the way that she supports clients and the spaces in which she is able to do so. Renie also told me:

What I found out was, over time, later, that most of my people were medical themselves, or they were people with a history of issues and wanted someone who knows those terms, who knows why they have to go to the high-risk hospital.

This addition blurs the line between her experiential knowledge and biomedical knowledge. While Renie is a doula, her familiarity with complications, biomedical language, and medical procedures has been jointly informed by her experience as a doula and training as an L&D nurse. Renie's description of why her clients seek her out complicates the common perception of those utilizing doula services and their motivations. It also suggests that there may be tension or difficulty in balancing biomedical and alternative sources of knowledge when serving clients who are considered high-risk, which poses questions about their ability to receive doula and birth services that draw from ancestral, embodied, intuitive, and other alternative knowledge forms.

### ***Knowledge Systems and the Construction of Legitimacy***

The scope of practice for birth doulas includes "explanation and discussion of practices and procedures" and expressly forbids a doula from conducting any "clinical or medical tasks" such as taking blood pressure or checking fetal heart tones (DONA 2017). While a doula cannot perform any clinical tasks or make medical decisions, the previous section highlights the importance of being versed in these tasks and processes in order to better support clients in a hospital setting. The function of possessing biomedical and other types of scientific knowledge

extend beyond supporting clients. Such knowledge can grant legitimacy to doula work as doula institutions contend for recognition by medical institutions that exclude and denigrate those without acceptable forms of knowledge and credentials.

Henley (2016) posits that possessing certain types of knowledge helps doulas gain legitimacy within different spaces (40). While the “alternative” knowledge system of intuition and embodied knowledge discussed earlier may claim authority within doula circles and doula-client relationships, its legitimacy is questioned in the biomedical setting of a hospital birth. Indeed, in my doula training, Leyla balanced both the scientific evidence for the impact of doula support and the benefit that she believes it brings to birthing people outside of the scope of what has been studied. Having some claim to biomedical or scientific knowledge as a doula when navigating the institutional hierarchies and interpersonal relationships of a hospital birth can provide some degree of authority or respect within that clinical space.

While doulas are not scientific practitioners, evidence and research are valued sources of knowledge within the doula community. Joy told me that her informational support is guided by the resources available on [evidencebasedbirth.com](http://evidencebasedbirth.com):

Mothers...gather a lot of information, but I don't know how they're coming up with answers. So I do present Evidence-Based Care. Look up evidence-based care dot com. And I utilize the resources there.

This website compiles the scientific research concerning the safety and/or validity of a variety of care options and interventions during pregnancy and labor and provides easy-to-understand syntheses of this research. For example, regarding inductions for due date (inducing labor at or after 39 weeks without other medical indication), [evidencebasedbirth.com](http://evidencebasedbirth.com) details multiple scientific studies, their key findings, and their flaws (Dekker and Bertone 2015). Such

knowledge is founded in biomedicine and created and compiled by biomedical practitioners, but its users and consequences being traditionally viewed alternative to biomedicine.

The importance of scientific knowledge in justifying the presence of doulas and alternative systems to hospital-based pregnancy management was evident when Renie vented her frustration with the U.S birthing system:

It's overkill that most births are required to be birthed in a hospital. That's not necessary in most cases. It's a normal, physiologically healthy woman bodily function. So lots of people that are low-risk, young, healthy, not on medication, pregnancy has been absolutely perfect...you don't need that level.

Here, Renie is using biomedical research and knowledge to support her claim that the U.S birthing system is fundamentally flawed. Employing biomedical knowledge can legitimize doulas and their claims within institutions that value such ways of knowing.

Similarly, Henley argues that research demonstrating the impact of doula work legitimizes the role of doulas as valuable practitioners in the eyes of clinicians and medical institutions, and that possessing and communicating this knowledge can elevate the status and authority of doulas in clinical settings (Henley 2016, 47). Indeed, the emphasis of the doulas I spoke to on their importance in communicating such information and evidence for demedicalizing pregnancy and birth was intimately related to their valuing of doulas and their own work. Likewise, DONA International advertises such evidence with pride. The front page of their website reads that their organization is “a leader in evidence-based doula training” (DONA, n.d.). Navigate to their tab, “What is a doula?” to find that just under the definition of doula, the website writes that, “Countless scientific trials examining doula care demonstrate remarkably improved physical and psychological outcomes...” (DONA, n.d.). Clearly, to mainstream doula institutions and individual practitioners, biomedical knowledge is an

important source of granting legitimacy to the profession and value for the work despite the non-medical role of these institutions and their practitioners.

By upholding the authority of this knowledge, mainstream doula organizations such as DONA International may be complicit in the construction of scientific knowledge as authoritative (DONA, n.d.). By emphasizing the value of doulas through scientific literature and evidence, mainstream certifying organizations seem to be striving for a proximity to medicine as a form of gaining legitimacy and acceptance by culturally authoritative practitioners and institutions. Additionally, doulas not trained or certified by these organizations could be viewed as less legitimate in the eyes of policymakers and practitioners. However, not all doulas look to these institutions and ways of knowing for legitimacy and authority. Cultural, ancestral, and community knowledge about pregnancy, labor, and postpartum care and support were all emphasized in my doula training as well. For doulas that work outside of the hospital setting and attend only home and birth center births, the currency of scientific knowledge about the role of doulas may have less value. For birth justice-focused doulas, their value and authority does not need to be legitimated by scientific or biomedical terms (Henley 2016, 42).

Alternative knowledge systems and sources of authority are challenges to the institution of biomedicine and its institutionalized harms that emerge during the provision of maternal care. The role of evidence and research and their importance in granting doulas legitimacy complicates the hierarchies of knowledge systems within the doula community, typically viewed as practicing outside and alternative to biomedical systems. The particular value placed on scientific knowledge in justifying doula work and its potential expansion highlights the consequences of the institutionalization of doulas. Valuing certain types of knowledge at the

expense of others is characteristic of knowledge-producing institutions, including current doula organizations (Bourdieu 1991, 5-6). As I discuss in the conclusion, further institutionalization of doulas within existing governmental and hospital programs can marginalize alternative ways of knowing in favor of doula practice founded in biomedical and scientific perspectives of legitimacy. Marginalizing intuitive, ancestral, and alternative knowledge systems, as I will argue, threatens the very processes through which doulas contribute to more positive birth outcomes and experiences.

### ***Moving between Timelines: The Application and Integration of Different Knowledge Systems***

“I had a patient who had a poor experience at another hospital.” Miranda, the midwife, recalled. The patient wanted a low-intervention, unmedicated birth and hired a doula. However, as the labor progressed, it became clear that the patient should receive an epidural and Pitocin because the patient was bleeding and labor was stalled.

“This is someone’s worst nightmare if they want an unmedicated birth. The doula said, ‘Yes, we want to go as natural as we can, and low-intervention. But we exhausted all of that. And there are medical interventions that can be used when needed. But we’re not doing them just because we can. We do them when needed.’” Miranda was then able to explain the different ways in which she could speed the progression of labor. After she explained the risks and benefits of both rupturing the patient’s membranes and administering Pitocin, the doula stepped in again. “I suggested that Pitocin might be a better option. The doula said, ‘Breaking the water may feel more natural, but you can’t take it back. You can always start Pitocin and then stop.’”

Miranda smiled, “And the birth, it was beautiful.” The patient that Miranda had described was facing a critical moment in her labor, both clinically and experientially. Indeed, there was a great opportunity for the continuation of violent birth experiences in this patient’s life given the divergence between their ideal birth experience and the clinical realities of their labor. I argue that this doula’s ability (and that of doulas in general) to recognize the multiple timelines of birth is the mechanism through which support is rendered in critical moments such as the one described in this vignette.

Although biomedicine treats birth as a medical problem, childbirth is a transformational phenomenon for parent(s), siblings, and larger family structures. For the birthing individual, the intensity of the emotional, physical, and potentially spiritual experiences that construct this transformation are left largely unattended: a larger-than-clinical phenomenon is brought into a restrictive and limiting clinical space, confining the perception and experience of birth to clinically relevant indicators. Because of the authority of biomedical knowledge in the hospital space, clinically relevant indicators construct the “clinical timeline” of birth and determine when certain activities of childbirth, like pushing, or when particular medical interventions, like placing an epidural or conducting an unplanned C-section, can take place (Strong 2020).

The emotional, physical, and spiritual changes a birthing individual may experience do not necessarily map onto the clinical timeline. Laboring individuals may feel as though they want to give up and stop pushing when the clinical timeline of birth demands that they push (Strong 2020). Initiation of the labor process might not map onto the clinical timeline as well, with inductions being used to stimulate what may clinically be interpreted as delayed labor (Davis 2019, 194). These sensations and experiences then form what I call

the “experiential timeline” of labor, which can be distinguished from the clinical timeline. These distinct timelines may overlap and diverge throughout the course of a labor. The multiple temporalities of labor can be understood similarly to the various temporalities of sexual assault investigation described in Sameena Mulla’s *Violence of Care* (2014). Though Mulla described a drastically different phenomenon, the experiential timeline of labor, much like the biographical timeline of sexual assault, is defined by an individual’s own framing of labor rather than institutional definitions and understandings of its beginning, end, and stages (Mulla 2014, 57). Similar to the biographical timeline that Mulla described, institutional spaces sideline the experiential timeline of labor, interrupting and reshaping an individual’s experience of labor with definitional, temporal, or interventional aspects of the institutional timeline (Mulla 2014, 60-65).

Consider the role that the doula played when Miranda had to explain to her patient that their labor must be induced. While to the midwife, the clinical indicators of needing an induction were clear, the doula was able to recognize that the sensations, knowledge, and goals of their client were not aligned with the clinical timeline of labor. The doula was able to bridge the two through gentle recognition of their client’s experiences and mapping the midwife’s clinical reasoning onto those experiences and values. The potential for this type of communication across and between timelines and bases of knowledge underscores the way in which doulas can create more positive birth experiences for their clients.

Because of the social, cultural, and personal significance of labor, maintaining the integrity of the experiential timeline of labor and attending to its needs becomes an important way to support positive birth experiences and outcomes for the birthing individual. Doulas can

act as ambassadors between the experiential and clinical timelines of labor. Doulas are not medical professionals, however, as I have demonstrated, they are proficient in the clinical timeline of labor without having to “write” or participate in it (DONA, n.d.). Instead, a doula can attend to both timelines, mediating disputes between them and softening clinical interruptions of the experiential timeline of labor. Personal narratives of labors attended by doulas highlight the role of doulas as ambassadors between the two timelines: “Paige [the doula] spoke about how important it is to know the details of the physiological process, the emotional markers of labor...” (Wilson 2014, 47). Because the emotional comfort of a laboring individual is the main priority of a birth doula, they are able to validate the experiential timeline within a clinical environment. This framework helps us understand why doula support can be so impactful.

Doula work extends the recognition of the experiential timeline of labor beyond the doula-client dyad until it has presence within the clinical environment of a hospital-based birth. Doula work can render the emotional, physical, and affective aspects of the experiential timeline of labor and of the laboring individual perceptible within experientially limiting clinical spaces. Attending to the spiritual, emotional, and physical needs of a laboring individual through physical touch, encouragement, and other relaxation techniques grounds a laboring individual in the sensory and affective aspects of labor and validates these experiences to the laboring individual themselves. As many of the doulas that I spoke to attested, telling a person in labor that what they feel is “normal” and that they are “valid”, are common support techniques.

Additionally, consider one way in which Lorie supports her unmedicated clients:

If [the nurses] come in to do an exam, even sometime saying, ‘Remember, she doesn’t have an epidural.’ Because they get so used to people not being able to feel anything.

Lorie reminding nurses that a patient has not received an epidural renders the client's experiential timeline of labor perceptible within the birthing space. The potential for the laboring person to feel pain and discomfort can then be considered by the practitioners. These support activities connect the doula to the client's experiential timeline of labor and elevates this timeline to one that is recognizable within and beyond the doula-client relationship. In the following chapter, I will discuss what constitutes and facilitates support in greater detail.

Diane and Lorie both spoke of creating opportunities for their clients to ask questions of their provider or process decisions privately:

I encourage the client to ask a lot of questions of their doctor, to process with their partner.

-Lorie

I will always create space for them to advocate for themselves and for them to ask questions. So like, trying to help slow down and help them process what is happening.

-Diane

Morton and Clift's (2014) insight that "doulas enter medical institutions with the goals of emphasizing emotional over technological triumphs and affirming the woman's act of giving birth, rather than the physician's role in delivering babies" (41) can be used to frame Lorie and Diane's actions. Doulas can give to the birthing person within relational networks in a clinical setting but also to the birthing person themselves during labor. Doulas facilitate the emergence of the birthing individual as "the main character" in their own narrativization of their birthing experience through the recognition and elevation of the experiential timeline of labor. Doulas create opportunities for their clients to function as agents in their medical decision-making and narrativization of their birthing experience through gentle resistance of the institutional routines and hierarchies that subordinate the experiential knowledge and timeline of birthing

people. In the following chapter, I will connect the foundations of support to the mechanisms through which doula work can resist institutional routines and violence.

### ***Conclusion***

Doulas are uniquely able to work in different spaces with vastly different values, routines, and hierarchies, and are expected to move between these spaces seamlessly. The conversations that I have had suggest that the different knowledge bases and systems that doulas draw from guide the ways in which they interact with different actors in these spaces and justify their presence in them. However, the types of knowledge that doulas do employ can come into tension—the need to justify the presence of a doula using scientific knowledge while simultaneously critiquing the institutions that produce and value such knowledge is just one of these tensions.

Instead of attempting to reconcile these tensions and contradictions, I believe there is value in sitting with them. These contradictions highlight where I believe doula work draws its strength from—the lack of being a formal part of medical and governmental institutions. The need for doula organizations (and therefore its members) to emphasize scientific literature that identifies the importance of their work is evidence of doula organizations holding scientific capital, and thus using such capital to compete with other knowledge-producing institutions (Bourdieu 1991, 6-8). While there are consequences of such organizations, which I discuss in the conclusion, this separation from the medical and governmental apparatus provides the opportunity for non-biomedical knowledge and skillsets to be valorized, funded, and developed such that allows for doulas to use those systems and skillsets in their practice.

The way that doulas interact with embodied knowledge and intuition highlights the radical role that they can play within a hospital setting. Creating the conditions in which a birthing person can take back control over their birth experience and narrative is radical in a medical system which dehumanizes patients and aggregates outcomes, and particularly important when considering the manifestations of the afterlife of slavery in medical institutions. The disregard of the experiential timeline of labor for Black birthing people continues, and the validation and elevation of this timeline in the face of the legacy of obstetric racism radically challenges continued violence.

The way in which doulas grant legitimacy and presence the experiential timeline of labor in a hospital space is intimately connected to the ways in which they support clients, including those from marginalized backgrounds. The potency of such acts depends upon the ability of a doula to listen, to validate, and to connect. Ultimately, these skills arise from a doula's belief in the intuitive nature of birth and birthing people, and the trust placed in their bodies and ability. The degree of doulas to trust and believe in non-biomedical ways of knowing could be seriously limited through the cooptation of doulas by medical and governmental systems, as I will discuss in detail in the conclusion. Recognizing a client's experiential timeline of labor through functioning as a technology of presence can allow doulas to better *support* their clients, which I will explore in Chapter Two. The trust doulas place in the bodies and experiences of their clients is foundational to their approach towards supporting their clients. In the next chapter, I will explore the relationship between presence and support, and draw distinctions between support and care.

## Chapter Two

“We cannot empower *anyone*.” Said our doula trainer.

*The faces populating the Zoom video squares exhibited various levels of understanding. Some trainees looked confused; others nodded in agreement.*

“What we do is that we meet people where they are, not where we expect them to be.”

The first day of the virtual seven-week doula training at a New York-based, birth justice-centered doula organization was far more than an orientation for the training. Our trainer, Leyla, was orienting us in the values of her organization, in the birth work community, in a decolonized, queered, birth justice-centered world of supporting pregnant and birthing people as a full-spectrum doula. As a full-spectrum doula, we must be prepared to show up for people in different ways in different spaces, she told us. We may transition from a pregnancy doula to a stillbirth doula unexpectedly. We may have to prepare our clients for dealing with Child Protective Services. As Leyla put it, we can expect to support a birthing person through their pregnancy, labor, and postpartum period.

Underlying the various roles we may play in the reproductive lives of birthing people as a full-spectrum doula is support, according to Leyla. After working in small groups to brainstorm “what support looks like,” Leyla highlighted what support does NOT look like. “Support is not your ego, your own opinions and expectations of others.”

Whether we were discussing the involvement of Child Protective Services in separating poor Black and Brown families or the needs of a person having received a Cesarian section, the word “support” kept on coming up, over and over again. Immediately, the nuances between care and treatment came to mind when our training cohort discussed centering the individual

in our work. However, as non-medical personnel, the doula scope of practice shifts the range of characterization of a doula's interaction with their client to one of care and support. Indeed, the definition of "doula" by DONA International, the foremost doula-certifying organization in the United States, is "a trained professional who provides continuous physical, emotional, and informational *support* to a mother before, during, and shortly after childbirth..." (DONA, n.d) [emphasis added]. This is of particular importance because while medicine is moving towards embracing person- or patient-centered *care* as the new model for health care delivery, the non-medical providers with such great impacts on birthing experiences and outcomes support rather than care for clients. What, then, are the boundaries between care and support? How can the perspectives of doulas on support inform the ways in which medical professionals care for pregnant and birthing people? Importantly, what principles and conditions do supportive practices depend on, and how can we protect them?

In this chapter, I explore how both intuitive practice and institutional/structural awareness guide the ways in which doulas interact with and support their clients. I expand upon the use of intuitive knowledge from the previous chapter and identify it as foundational to doula support. By drawing upon my training experiences and the ways in which the doulas that I interviewed characterize their practice, I lay out a series of principles that can characterize support as a distinct practice from care. I then frame support as a radical act of intentionally making aspects of a birthing person present by drawing upon Lester's theorization of technologies of presence (2019). I suggest that the fundamental difference between support and care is that true support cannot be violent. The radical shift towards centering the needs, values, and experiences of the birthing person in an active, intentional, and fluid way gives

doula support its power in changing birth experiences and outcomes for the better. Ultimately, I draw attention to the ways in which institutionalization of doulas can interfere with the mechanisms through which doulas support clients.

### ***Intuitive Bodies***

“Trust the intuitive nature of the female body,” Joy concluded after supporting her first home birth. A close friend had asked her if she believed they were capable of having a free birth, and after journeying with them through the process, she learned how “natural” pregnancy and labor are, contrasting with her years of experience as a labor and delivery nurse. The body, then, knows how to birth. “Trust[ing] the intuitive nature of the [birthing] body” recognizes, values, and gives authority to the bodily knowledge and routine of labor, like the midwifery model of pregnancy. As Renie put it:

Pam England said, ‘You don’t birth a baby through your brain.’ And all these engineers, they want all the facts. What’s the first stage, what’s the second stage...it doesn’t really mean a whole lot when you get down to it. You birth through your body.

Intuition, feelings, sensations, urges, all become prioritized ways of knowing the progression of labor and any necessary interventions, according to this perspective. Doulas not only trust the body itself to birth; they extend this trust in bodily and embodied knowledge into the philosophy that underlies the physical and emotional support they provide.

I believe that most women have that intuitive nature. Especially when they’re pregnant. I feel like their radar really kind of increases, and they have that... capability to say, ‘This is what I want. That is not helpful to me.’

-Joy

Because, according to the trust that doulas place in the intuition of the birthing body, the body already possesses the knowledge and skills to birth, the body knows what it needs in

order for labor to progress. The birthing person becomes hyperaware of those bodily needs during pregnancy and labor, according to Joy. Renie also described a similar level of awareness and trust in it over institutional or formalized knowledge. One client she served as a volunteer doula was attempting an unmedicated labor for her sixth birth:

I get there and say, 'Let me get a birth ball.' Well, she's never heard of it, and thought it was kind of goofy. She got out of bed and sat on it. She had never seen it used. All of a sudden, it makes her feel better during her contractions to bounce on it like a basketball. And I was thinking, 'That's not the way...' but that's what was working for her. And then she says, 'The baby's coming!'

Trusting that the body, and therefore the birthing person, knew what was needed to encourage the progression of labor was central to the support that Renie provided this client. Renie's knowledge about the typical way in which a birthing ball is used during labor became secondary to the client's embodied knowledge regarding their comfort.

Working to make a birthing person more comfortable, then, is founded in an understanding of the power of the birthing person's ability to birth safely and know what is necessary in order to do so. Comfort measures, whether they be physical or emotional, keep the laboring person from "get[ting] stuck" (Joy's words). The mental or emotional state of the birthing person, then, relate to the progression of labor, and any discomforts can represent a mismatch between what the body (and the birthing person) knows it needs and the environmental or emotional characteristics of the birthing space. "It's whatever she wants, whatever she needs. If it's movement, if it's music..." Joy said when describing the comfort measures that she employs during a hospital birth. Joy's attention to these needs can be understood in that she, and other doulas, may believe that the wants and needs of the

laboring person, regardless of the nature of the request, reflect embodied, subconscious knowledge about the process of labor that should be trusted.

Intuitive practice relates to the ways in which doulas interact with the experiential timeline of labor and presence. Through trusting intuition and embodied knowledge, doulas connect to the experiential timeline of labor to the ways in which the birthing person is acknowledged within the birthing space. The characterization of doula practice as trusting the intuition of the body is the foundation of support: by trusting the pregnant body and pregnant person to “know” what is best, a doula can then take actions that center and elevate such knowledge. In the first chapter, I discussed how this way of knowing may be used differently and leveraged differently depending on the space in which a doula is operating. Importantly, the way in which support is grounded in embodied and intuitive knowledge directly challenges orthodox ways of knowing and operationalizing knowledge in biomedical institutions. Heterodoxy in the eyes of biomedicine is then key to doula support. This recognition highlights the importance of doula work being founded, cultivated, and transmitted outside of biomedical institutions in order to preserve the heterodoxic knowledge that underlies support. When considering the means through which popular legislative ideas seek to expand access to doula services, it is important to consider how such methods could threaten intuitive practice in doula work.

### ***Intuitive Work***

As Leyla taught us in our doula training, being “in tune” with clients is an essential way of relating to them during their pregnancy and labor (her language).

*There seemed to be a collective understanding in the virtual space as Leyla told us that doula work was all about connection. Connection to the birthing person, their body, their spirit, their emotions. Connection to our own body, spirit, and ancestors. She told us that as we practiced, we'd feel sensations in ourselves that were representative of some change, experience, sensation of the birthing person. As doulas, our sensations were more than just feelings. They meant something in the context of our work, and we should trust and listen to them.*

The trust in intuition extends beyond valuing a birthing person's embodied knowledge regarding their own labor. Doula work is inherently intuitive, built on the trust of not only the birthing person's intuitive nature but one's own. A doula's own intuition guides their interactions with their clients and the support that they provide. For example, Joy told me:

I'm a very intuitive coach. It's like we're journeying the same road together. I can kind of sense what her fears are and what her frustrations are. Whether she really likes this doctor or midwife a lot...or not. And I support her through it.

By forming a relationship with clients throughout the prenatal period, Joy is able to cultivate her sense of intuition about that client's emotions and comfort. Based on what she intuits about her client, Joy assesses their goals for their pregnancy/labor and their values. Of course, this process is imperfect. Intuition uses an internal line of reasoning of which the individual is not consciously aware, allowing their own judgements and values color the interpretation of the client's outward expressions of emotion or comfort. However, being able to respond to a client's discomfort despite the fact that it is not verbally expressed, a doula intuiting that a client is uncomfortable with a provider or course of action, can protect birthing people, particularly those of color or those on public health insurance, who may fear reprisal for speaking out against a hospital routine. Thus, intuiting a client's discomfort with a provider, a care plan, or an intervention complicates our understanding of support and centering the goals, values, and experiences of the birthing person. Intuition can play a valuable role in

protecting and supporting those who may not verbally express their desires or discomforts in clinical spaces for a variety of reasons, yet can also become a filter through which non-verbal cues are interpreted in the context of a doula's own values.

“Being in tune” and connecting with a client can be more immediate as well. Intuition guides practice when the doula and birthing person do not form a longer-term relationship. Renie has served as a volunteer doula in a hospital setting in the past. When I asked how she is able to support clients that she doesn't know, she told me, “You can meld with a birthing person, without background or books or anything.” When it comes to physical support during labor, biomedical knowledge or even a previous relationship with a client is second to the intuition of a doula and their ability to connect in a bodily sense with their client. She described a time when she was called in to support a person who was attempting a VBAC, who intended to deliver vaginally without them having previously discussed it. These details, or lack thereof, Renie claimed, did not impact how she supported this client. “Every time there was a contraction, we plied,” she said. “We plied all night. She delivered a nine-and-a-half-pound baby in the morning.”

The repetitive, shared motion of a plié connected Renie to her client in a bodily sense, both pliéing without providing or demanding an explanation for hours. By sharing in this embodied experience, Renie was able to fall into the rhythm of the birthing person's experiential timeline of their labor. This may be the “melding” that Renie described as central to supporting people during labor.

This level of connection between birthing person and doula was idealized during my doula training. “Hands are sacred and blessed,” Leyla told us. We were taught that doula work

is inherently intuitive and embodied: connecting to a birthing person through touch and *feeling* their sensations, emotions, memories, and experiences is how to best support someone physically and emotionally during pregnancy, labor, and the postpartum period. Knowledge and experiences being stored in the physical body was taught to us when we learned the concept of “cellular memory,” explained as the theory that the body itself stores memories outside of the brain. As a doula, we can create cellular memory in someone else through touching them with our hands. Through our hands we could also connect to that individual’s cellular memory.

Reading and imprinting this cellular memory is a bodily practice, and such memory is embodied by the doula and the birthing person. According to Leyla, a doula might even “feel” when a client is going into labor, they experience a contraction, or have a question or concern. This is more likely to occur when a doula is experienced, has a longer relationship with a client, or is very connected with them “vibrationally.” So, gut feelings or intuition can then sometimes be the embodied manifestation of experience. Additionally, birth work and its techniques as an ancestral practice informs the importance of intuition in doula work. Forming these vibrational connections with birthing people was described as an “ancient technology” and “practice of being”, that these connective practices also connect the doula to their ancestors and their knowledge. Intuition can then also be thought of as manifestations of this ancestral knowledge that emerges through and from embodied practices.

It is important to understand that for many birth workers, intuition is not simply a “gut feeling”, but is instead a valid way of knowing that results from ancestral, embodied, and vibrational knowledge, and can and should inform how one interacts with a birthing

person. Indeed, doula work depends upon intuition and other marginalized ways of knowing in the way that it is taught, discussed, and practiced. The integral connection between the doula and the birthing person within the experiential timeline of labor, which I discussed in the previous chapter, depends upon the employment of intuitive knowledge in doula practice. That recognition of and interaction with the experiential timeline of labor depends upon emotional, physical, spiritual, vibrational, cellular connection between the birthing person and the doula. Such connections form the foundation of support. Such connections can only take place outside of institutions that marginalize these ways of knowing, being, and relating to others. These connections ultimately would be threatened, rendered invisible, or formed in precarious or incomplete ways if doula work was founded in a space that subordinates these ways of knowing and connecting. The importance of preserving the spaces and mechanisms through which doulas are taught about and allowed to connect with clients in these ways comes into focus when considering the consequences of institutionalizing or coopting doula work.

### ***Birth Workers as Stewards of Knowledge Production and Transmission***

“I assisted in the delivery of over two thousand babies!” Joy said of her experience as an L&D nurse.

“That’s a lot of babies,” I remarked.

She nodded. “A lot of babies. And a lot of moms. A lot of doctors, a lot of clinicians. You know, that’s just a lot of care...If I had known back then what I know now, I would have been running my own data of what did work, what didn’t work.”

As described earlier, doulas often take up the mantle of transmitting knowledge about the evidence behind interventions during labor and alternative forms of care and treatment.

Joy wishing that she had conducted her own research about birth practices is not unusual: doulas and other birth workers function as stewards of producing and transmitting knowledge that is alternative to that of biomedical and institutional knowledge about childbirth. Whether it is knowledge about medical interventions during birth, providers and hospitals that birthing people of color should avoid, or alternative and ancestral birth practices, doulas help create, transmit, and protect knowledge that can threaten or oppose biomedical and institutional narratives and routines.

During my doula training, Leyla stressed that doulas were in a unique position to learn which providers, which institutions were safe for birthing people of color, and which were not. As individuals who attend many births and encounter a wide range of providers, institutions, procedures, and routines, doulas accumulate knowledge about which providers they believe to be violent, and which institutions, policies, and procedures must be reformed. Leyla reminded us that such knowledge places doulas in a position to advocate for and demand reforms, and that by disseminating knowledge, doulas can protect community members from violent providers and spaces as well.

Community-based knowledge production and dissemination directly challenges the hierarchical and exclusive system of learning and credentialing of medicine. Community-based doulas can then function as alternative sources of knowledge about birthing options in a particular community for those members that may not have access to authoritative sources of knowledge or seek to avoid such sources. It is critical to preserve community-based knowledge production and transmission because such knowledge fuels demands to reform, reshape, and restructure maternal health care policies and practices. Indeed, advocacy by community-based

doula organizations has led to increased political awareness and action regarding the Black maternal health crisis (New York City Department of Health and Mental Hygiene 2019).

Within the birth work community, midwives are also considered to be stewards of both ancient and specialized biomedical knowledge. Midwifery is certainly revered an ancient and ancestral practice by some birth workers, who feel that a “return” to midwifery is key in improving birth outcomes and experiences. “Midwifery, I mean, it’s Biblical,” Joy said, “Midwives have been around for thousands of years.” Despite midwifery being such an ancient art, midwives are also considered to both continue to hold “out of fashion” biomedical knowledge and be innovators within biomedical spaces. Both Joy and Renie incorporate Spinning Babies®, a series of positioning, massage, and other techniques to facilitate easier childbirth by balancing the pelvis and potentially repositioning the fetus, into the services they provide to her birth clients (Spinning Babies®, n.d.). Evidence-Based Birth, an informational website discussed in the previous chapter, is midwife-founded as well.

Midwives are considered holders of forgotten biomedical knowledge as well that offers a more desirable (less interventionist) birth experience in the case of a complication. Joy offered the example of vaginal breech deliveries, which, according to her, only midwives remember how to practice. Thus, these many different types of knowledge that are held and produced by midwifery are ultimately considered valuable within the doula community because they represent a departure from modern obstetric practices. The nature of that knowledge, whether it is ancestral, intuitive, scientific, or biomedical, bears less relevance on its value overall than the fact that it challenges, or is alternative knowledge to, modern obstetric knowledge.

### ***Distinguishing Care from Support***

Medical anthropologists have long recognized that caregiving by physicians is sidelined in a health care system that fails to invest in cultivating caregiving in its trainees and clinical environments (Kleinman 2012, 1550-1551). “Emphasizing [the] human aspects” of diagnosis and treatment and presence despite a prognosis or outcome are central to caregiving for medical professionals. Kleinman writes that the terms “‘taking care’ and ‘caring’ imply the cultivation of the person and the relationship through the practices of attending, enacting, *supporting*, and collaborating” [emphasis added] (Kleinman 2012, 1550-1551). These active aspects of caregiving then seem to encompass the relationship between doulas and their clients. Despite this apparent overlap, in both my experienced being trained as a doula and the conversations I’ve had with doulas, support, not care, is foundational in praxis.

Based on my training experience and the conversations I have had with doulas, there are three important characteristics of support that may distinguish it from care: (1) support centers the values, goals, and experiences of the birthing person (2) support is active, intentional, and informed, and (3) support is fluid. Whether a client is pregnant, laboring, or postpartum, doula support is characterized by taking informed, intentional action, as Renie highlighted: “You can care but not know how to personify that.” Renie distinguishes care from support on the basis of embodiment. *Caring*, then, becomes a feeling. Indeed, Renie seems to confirm this when discussing the role of a doula in supporting the partner of the birthing person: “A partner cares more than anything, but may be clueless and scared shitless more than anything in the world.”

Instead of caring *for*, Renie's comments seem to focus more on caring *about*, where care is a feeling rather than an ethic that guides action. A variety of activities are described as forms of support by doulas in both surveys and interviews, from education about birthing options during the prenatal period to discussing the emotions of labor. Despite this variety, all of these actions have an intended outcome and are informed by a body of knowledge or goal.

The nature of the support provided by a doula is mediated by the client's values, goals, and experiences. For example, Joy explained that for "a really natural personality," her support during pregnancy is tailored towards achieving that client's goals of avoiding as many medical interventions as possible:

I will say to them, 'You need to have your questions ready at the 20-week ultrasound.' Or, 'You're going to have to think about what you want to do about the gestational diabetes test.'

Supportive activities, then, are informed by the specific characteristics of the birthing person, their unique goals in pregnancy and labor, and their broader values.

"What we do is we meet people where they're at, not where we expect them to be." Leyla told us during our first training session.

The words of my doula trainer captured the key element of support. Indeed, in my conversations with doulas, meeting clients where they are at is foundational to their work. While doula support and midwifery care are often thought of as alternatives to mainstream modalities of receiving pregnancy care, each of the doulas that I have spoken to have been challenged to support pregnant and birthing people with a vast range of lived experiences that influence their goals in their pregnancy, labor, and postpartum care and support. Doula support is not necessarily the suite of activities, education, and advocacy that

stands as a bulwark against the interventionist medical model. Instead, doulas are informed by the specific goals, values, and lived experiences of their clients so that they can provide the best support possible.

Consider how Diane described the ways in which she supports her clients. Diane is a social worker-turned-doula. Oftentimes, she supports clients from marginalized or low-income backgrounds. She is keenly aware of how these factors mediate the medical care her clients may receive. “The patients weren’t valued,” she told me. An important part of her role in supporting such a client during a hospital-based birth became creating the space such that her client could have their voice “be really heard and valued.”

While all of the doulas that I spoke to emphasized the importance of educational or informational support at all stages of their working relationship with their client, the education and information that Diane provides to her low-income clients serves to alter their positionality within the hierarchy of the clinical space. Diane’s support intentionally presences her clients as informed, potentially vocal subjects that can then be treated differently by care providers. When working with low-income clients, Diane’s support functions as a technology of presence as defined by Lester (2019), to render a client “intelligible and perceptible” to practitioners in specific ways that challenge dehumanization and disempowerment.

This intentionality is what defines the education and information that Diane provides to her low-income clients as supportive. Information about the different interventions that one may encounter during a hospital birth can help all clients feel more prepared to make decisions during their hospital birth, however the intention of resisting provider assumptions and routines for low-income patients on public health insurance motivates the activity of a doula

informing her client about these interventions. Thus, the activity becomes *supportive* because it is informed by an awareness of how the client's insurance status mediates her subjectivity within the processes of giving and receiving care in a hospital setting.

Thus, doula support requires a nuanced understanding of their goals in pregnancy and labor; their past experiences with medical institutions; generational trauma; the racial, ethnic, socioeconomic, linguistic, and other markers that impact a birthing person's positionality within the hierarchy of medical institutions. Doula support, then, attends to the various social, cultural, and historical realities of pregnancy and labor in the United States that manifest within the clinical caregiving space and the intersubjective processes within that space. The intentional nature of doula support is not just defined by action but by a specific attention to the ways in which action (or lack thereof) mediate the presence of the birthing person as a subject within the hospital space and caregiving and receiving relationships.

Intentionality can take on more subtle tones as well. Consider a story shared by Lorie, a doula who also works with pregnant individuals in crisis situations. During our interview, she told me that one of her clients was a young woman of a racially marginalized background. "She said to me, 'They treated me like an addict the whole time,'" Lorie recalled, sighing. "And I felt like, even if I had been sitting in the corner and not said a word, they would have treated her like a human." While I have previously claimed that support is defined in part by its active nature, the absence of Lorie from this woman's labor highlights the potentially supportive nature of *presence* itself.

In her ethnography *Famished*, Rebecca Lester defines a technology of presence as having two distinct features, "(1) it involves an experience of immediate, grounded, and

engaged connection to the world... (2) it renders one as perceptible and intelligible to others as a legitimate subject in local terms—a relational sense of ‘being there’” (Lester 2019, 65). While Lester applies these definitions to the affective and interpersonal consequences of eating disorders, I will engage with the ways in which doula support presences birthing people in both of these ways later on. However let’s first understand how *presence* can be active, intentional, and informed.

Birthing people with marginalized identities like the woman Lorie described face multiple levels of discrimination in medicalized settings. Dana Ain-Davis writes about the expectations of young-appearing Black women birthing alone in a hospital in her book *Reproductive Injustice* (2019). Young-appearing, addicted, incarcerated, Black, Brown, and Indigenous bodies are subject to various moralizing assumptions when pregnant and birthing alone. The presence of a non-medical support person, including a doula like Lorie, can interfere with either the formation of such assumptions, or the passive or active responses to them by medical providers.

All the doulas that I spoke to and almost all that I surveyed explicitly shared that they understood the deep impact of their presence on the birth experiences of their clients (“Doulas are a great piece to enhancing birthing,” said Renie. “I attempt to recreate home for them [at the hospital],” described Joy). Lorie herself told me that she feels that her presence might be her greatest contribution to a client’s birth experience. However, Lorie subtly distinguished between her presence at a typical birth and those of the individuals she supports of marginalized backgrounds when sharing the encounter above. Lorie understands the power of her presence in that situation within the intersection of her client’s substance use disorder,

race, and age and how those factors mediate the opinions of medical providers and their expectations for the caregiving and receiving processes. Presence in this situation and those similar can then become a form of support because the doula's presence becomes an intentional act of resisting the interpellation of a client through caregiving and receiving processes as one or multiple of the stereotypes providers' may hold about addicted, pregnant, and single people.

Centering the values, goals, and experiences of the birthing person requires the doula to actively resist espousing their own viewpoints, as doulas work with clients who schedule C-sections and inductions, those that want epidurals or hospital-based births and to be seen by an obstetrician. While the doula may internally interrogate the motivations of a client who actively seeks medical interventions during labor, doulas seem to agree that their role is not to directly question those choices and the values of that client. Doulas recognize each client's individuality and right to have the pregnancy and birth of their choice—including a medicalized one. Renie told me, "Once a woman makes a decision, for a million and one reasons, to get care at one place, to see a certain provider and a particular type of care, you support that decision." While it may be difficult for a doula to negotiate their personal values with the type of care a client is receiving, the doula's role remains to contribute to their client's ideal birth experience. "Once they've made a decision, you support them. You don't take down the medical model in the hospital."

Or as Diane put it, reflecting my own learning during training:

I personally just try to meet my clients where they are. Always providing them with education, all of the options, but ultimately, it's their decision. It's their birth. It's their labor and delivery.

Regardless of her own personal beliefs and values about medical interventions, types of providers, and types of care, her role is to uplift and contribute to the realization of her *client's* vision for their pregnancy, labor, and postpartum care. It is this act of centering the goals of the birthing person over those of the doula (or any institution) that makes doula support so radical and so different from care. Hospital systems that prioritize profits and hierarchies, that are built by and within racist structures, are spaces that are not conducive to purely pursuing and manifesting the goals and visions of its patients, particularly when such goals and patients may not necessarily align with the institutional goals of the hospital. A doula, which as discussed previously, is not beholden to the hospital's values and goals, who can operate within and outside its boundaries, can uplift the experiences, values, and goals of a birthing person in a space that inherently stifles them. Support, in its ideal form, can resist the violence of medical care, from elevating the status of the experiential timeline of labor to intentionally presenting a birthing person as a particular type of patient.

Doulas recognize that supporting a client's ideal birth, even if it actively involves medical interventions, becomes more difficult when a client is faced by the neglect, disregard, or even contempt by providers as a result of the client's race, ethnicity, insurance status, or other factors. Diane described an experience she had when supporting a client who received public insurance:

She really wanted an epidural. They refused to give her one. I mean, we labored through the night. Like, it wasn't their 'Wasn't enough time.' We ended up having to labor overnight the whole time, and she ended up having an unmedicated birth. But she asked routinely for [an epidural] and they never gave her one.

Diane anticipated a potential line of reasoning, whether justified or not, that could prevent her client from receiving an epidural, an important goal for their labor. Knowing that “the [Medicaid] patients weren’t valued” (her words), she prepared her client for the reality that their wishes could be discounted. In supporting her client’s goal of having a medicated birth, the preparation of her client to request an epidural multiple times because of her insurance status becomes a form of support because it is informed by the client’s insurance status and intentional in its effect. Thus, when centering the goals and values of this client, Diane’s awareness of the consequences of the client’s insurance status informed the type and goal of her actions, mediating how her support took its form.

Centering the goals, values, and experiences of their clients enable doulas to recognize the individuality of each client that they serve. The doulas that I spoke to starkly contrasted this approach with the one-size-fits all treatments and recommendations that characterize medical care, resulting from institutionalized and standardized routines. Renie, who worked as a doula for years before becoming an L&D nurse, told me:

I was shocked when I became an L&D nurse. Dr. So and So’s patient would come in. You go in a binder and find admit orders for when a patient comes in. You have an admit protocol and that’s how the doctor wants everything to be done for the labor. It has everything from the size of the gloves needed for the vaginal exam, how the mom will be monitored... I thought it was individualized.

These routines that have little room for individuality contrast with the attentive, intentional, and one-on-one support that doulas provide. Indeed, these routines can cause friction between the institutional practitioners and patients whose needs and desires do not fit neatly within the parameters of a medicalized hospital birth. While doulas can serve to guide nurses and other medical providers through physical comfort techniques and strategies for

promoting labor progression when a client wants an unmedicated or more “natural” birth, they can encounter resistance to requests for nurses to step outside of their institutional routines. Lorie often works as a partner with nurses when a client wants an unmedicated birth. She described the resistance she sometimes receives when supporting such a client’s goal:

I do feel like if we’re at a birthing place where they have to blow up the tub and fill it, that there’s definitely like, ‘Ugh. Are you sure? This is a lot of work. Are you really going to get in the thing?’

Though this friction emerges interpersonally, these actors are not entirely responsible for its occurrence. Fundamentally, it is the American health care system that discourages individualization of care and deviations from institutional protocols and routines because of its profit-seeking motivations. Doulas functioning outside of these routines allows them to intentionally insert themselves within them to disrupt or mediate the ways in which providers and the space interact with clients. Operating on the outside of these routines also enables doulas to provide support as an intentional and individualized act rather than as a routinized process.

Providing educational and informational support about one’s options for care and interventions during pregnancy and birth is a central part of the support doulas provide during pregnancy and labor. Each of the doulas that I spoke to emphasized the importance of education as a part of their work. “I am a huge advocate for education” was Joy’s immediate response when I asked her about the support she provides. Diane told me that support during pregnancy is “providing them [clients] education about their upcoming labor, their choices, the options they have...” Some doulas feel that birthing people do not feel equipped to question

the medicalization of pregnancy and labor for lack of information and education about medical interventions. Joy told me:

They [birthing people] give tacit agreement to their doctors because they haven't done their homework. I do feel like these women that are not supported... that they don't know any better, and the doctors, I think, don't give them as much time...

How can centering the values and goals of the birthing person be reconciled with the educational nature of doula support? How can doulas educate without perpetuating harm and advancing their own agendas? The education and information that doulas provide is fluid, based on the expressed or intuited needs of a client and the context in which support is being provided.

Joy orients the educational support that she provides based on her initial interview with a client. She told me that she tries to understand "what they bring to the table" and "how far" the client is in both their pregnancy and understanding of their care options. Assessing a client's attitude towards biomedicine and medical interventions helps Joy frame the information she shares with the client such that it reflects the goals and values either directly expressed by the client or intuited by Joy. Like Joy, Renie encourages her clients to seek out all the information about a provider, hospital, or birthing center that they can. She emphasized that this level of guidance to interrogate the care one might receive must be limited to the prenatal period:

Prenatally, you can suggest the mother to ask tough questions, get a tour of the hospital or birthing center, to take their childbirth classes. And based on that, the mother can make decisions.

Lorie's statement about her role in advocating for her clients encapsulated these perspectives perfectly:

I am never a decision-maker...I would call myself client-led. I'm not going to dump everything I know about every part of labor, parenting, you know...let the client lead.

“Letting the client lead” can include expressed, intuited, or observed preferences, discomforts, and curiosities when it comes to different types of care options. Of course, the interpretation of the intuited and observed by the doula presents the opportunity for her own viewpoints to color her perspective, making this type of support activity messier than others. Once again, assumptions, stereotypes, and biases of the preferences/discomforts clients of marginalized backgrounds could emerge. Once again, the violence of racism and other forms of discrimination can be perpetuated by imperfect, though well-intentioned, intuitive acts.

As mentioned earlier, the nature of educational and informational support changes based on a variety of factors, including the stage of pregnancy and labor that a client is in. Doulas drew a strong line between educational and informational support while a client is pregnant and during labor. While the fundamental goal of this type of support remains similar during these two distinct phases, to support a client’s capacity to make a decision that centers them, the nature of this decision changes. During pregnancy, doulas support a client in creating a “birth plan” or a “plan A.” The consequences of the decisions being made are not immediate, and clients are typically not being rushed by the temporality of a hospital birth. Once a client is in labor and decisions about medical interventions must be made, the educational and informational support provided by doulas takes on a new tone. While the goal is still to help clients make a decision that centers them, the range and nature of the information provided is limited by the time constrictions of the clinical timeline of labor. One of the most potent ways in which doulas can lead to more positive birth experiences is by communicating between the timelines of labor, as will be discussed later.

Recognizing these different timelines, doulas amend the information they provide to meet the demands of a hospital birth and the specifics of labor for that client. The doulas that I spoke to generally agreed that labor is the wrong time for a doula to encourage a client to explore other care options, and instead that any information and education provided must be limited by the choices the client already made and their health needs. Educational and informational support, then, seems to function not to encourage a client to make a *particular* choice, but instead to provide the knowledge and resources so that a client can make the choice that best reflects their own goals, values, and experiences. The information provided by doulas fits the established framework of support as it is intentional and fluid based on the stage of pregnancy or labor a client is in and their expressed or intuited values and goals.

In the previous chapter, I shared a situation described by the midwife Miranda about a patient requiring induction who was attempting an unmedicated birth. Miranda believes that the information support provided by the doula helped create such a positive birthing experience for that individual:

The doula said, 'Yes, we want to go as natural as we can, and low intervention. But we exhausted all of that. And there are medical interventions that can be used when needed. But we're not doing them just because we can. We do them when needed.'

This one vignette illustrates the defining characteristics of support that I have laid out in this chapter. When the client was pregnant, the doula centered the client's values and helped create a birth plan that reflected their goal of having an unmedicated birth. When it became clear that the original birth plan could no longer be followed, the doula mediated the support provided and patient-provider interactions based on the client's recognized value of minimizing interventions during birth. The informational and emotional support provided was tailored to

uphold that goal while addressing the client's clinical needs within the limitations in decision-making because of the stage of the client's labor and nature of a hospital birth. Doula support shifted this individual's birthing experience away from one of potential violence to one because the doula was able to embody the values and goals of the birthing person and reflect such values in the information provided and the ways in which they interacted with the midwife.

Support is what makes doula work so impactful. Understanding its unique characteristics and what differentiates support from care allows us to reimagine how health care providers, birth workers, and others should interact with pregnant and birthing people in order to create the most positive birth outcomes and experiences. The doulas themselves distinguished support from care in multiple ways. First, care was often used as a stand-in for *medical* care. Joy discussed her years of experience as a labor and delivery nurse as having witnessed "a lot of care." Care, and particularly medical care, can be and often is violent towards marginalized bodies. Support, on the other hand, cannot be violent because it should advance the achievement of the goals of the person being supported and contribute towards producing an outcome that the individual defines as desirable rather than any outside individual or institution. In the conclusion, I will discuss the overlap with and tensions between support and patient or person-centered care, an increasingly popular model of medical care delivery, as frameworks for interacting with birthing people. While these two models may be similar on the surface, the motivations and institutions underlying these practices, when interrogated, reveal important differences between the two.

### ***Doulas as a Technology of Presence***

“Sometimes, that’s what I think is my greatest contribution... my presence.” (Lorie)

From sitting with a birthing person who would otherwise be alone to interacting with clients in particular ways, the potency of doula support in altering birth experiences and outcomes can be attributed to the ways in which it mediates how the birthing person is connected and perceptible to themselves and others in the birthing space. Understanding doula support through the lens of presence of the birthing person can elucidate the powerful mechanisms through which support can resist and reimagine caregiving and care receiving dynamics in the space of a hospital birth, particularly for birthing people more likely to face discrimination and bias due to their race, ethnicity, insurance status, age, immigration status, and English-speaking ability.

By calling upon various support techniques mentioned by the doulas I interviewed, I frame such work as technologies of presence as defined by Rebecca Lester in her 2019 ethnography, *Famished*: “a suite of culturally informed bodily, affective, cognitive, psychological, and interpersonal practices that work together to conjure a form of being that has two distinct features, (1) it involves an experience of immediate, grounded, and engaged connection to the world... (2) it renders one as perceptible and intelligible to others as a legitimate subject in local terms—a relational sense of ‘being there’” (Lester 2019, 65). Doula work maps onto these two ways of presencing their clients through connecting to a client’s experiential timeline of labor and intentional ways of being and communicating in the birthing space.

Physical and emotional connection between the doula and the birthing person is a crucial and immediate component of doula support during labor. Lorie told me that the first thing she does when she steps into the hospital room when attending a labor is to “immediately connect” to the birthing person. Likewise, Joy told me that during the early stages of labor, her role is to listen to and enact whatever the “[birthing person] wants, whatever [they] need”. Doing so lets the birthing person express the little discomforts they are experiencing in the birthing space, according to Joy. Such recognition and communication only occur when or if the doula asks, she continued.

The strategies of both Lorie and Joy help connect the birthing person to their internal world and external environments. By shifting discomforts, thoughts, emotions, sensations from the birthing person’s internal world to tangible objects in the birthing space that can be recognized and interacted with, doula support works to create the “immediate, grounded, and engaged connection to the world...” that technologies of presence function to do (Lester 2019, 65). By meeting the now perceptible desires and needs of the birthing person the doula presences them as a subject with power over their environment, as a subject whose wants and needs carry weight beyond themselves. In a birthing space that is characterized by hierarchies that render patients relatively powerless, doula support functioning as a technology of presence can radically shift some power back into the hands of the birthing person.

The novel and often uncomfortable physical and emotional sensations of labor are also reinterpreted by doulas as they provide emotional support to their clients. Lorie expressed that one of her most important roles during labor is to “normalize everything.” As clients experience new, uncomfortable sensations during labor, Lorie’s role is to listen to the fears that arise and

assure her clients that, “[They’re] doing great. This is normal. Everything looks good.” The emotional reassurance that Renie provides extends further, as she helps a client and her partner reframe the sounds, sights, and smells of a normal labor:

I have a class and I’m working with couples...and I’ll get down on my hands and knees at some point and start moanin’, groanin’ things. And these are common noises they’ll hear, so they should know. That makes the partner feel completely panicked, ‘Oh dear Jesus, we need to stop.’ But to a doula, that means ‘alright, that was a good one. We’re getting somewhere.’

Renie reframing and reinterpreting the sights, sounds, and smells of labor alters the way in which her clients are connected to themselves and their bodies during labor. By shifting their interpretation of their bodily functions to provide new meaning to sounds, feelings, and functions that are typically thought of as unpleasant and undesirable, Renie helps clients ground themselves in new and unfamiliar ways of embodiment and connection defined by the liminality of labor. Such informational and emotional support allows the birthing person to connect to the outside world from a position of confidence and safety, with some degree of control over their environment and at least emotional comfort with the unexpected and unpleasant internal feelings of labor.

Another consequence of this type of support during labor is that it situates the birthing person as the primary focus of the birthing space. Language and actions that center the birthing person (“*You’re doing great*”) establish them as the “main character” within the birthing narrative and experiential timeline of labor. Through probing questions and by meeting a client’s physical comfort needs, doulas facilitate birthing people to be perceptible to themselves as agents with real, valid feelings and some degree of power within the birthing space. Internal subordination of embodied knowledge and its legitimacy is directly challenged

by the way that doulas connect birthing people to themselves and their internal and external worlds. Understanding the power of doula work in challenging the dehumanization and disempowerment of birthing people within medical structures from the lens of presence illuminates the conditions under which such radical acts are possible: a connection to and trust in intuitive bodies and intuitive work is fundamental to the function of doulas as a technology of presence. As Lorie recounted:

I remember one situation where the mom had had an epidural was having trouble pushing. I went out to use the restroom and on my way back, at the nurse's station they stopped me and they were like, 'She's doing a terrible job and she's...what are we going to do if she doesn't learn to push right?...So that was really interesting. But they were asking me to join them in a solution.

Doulas recognize the importance of the way that medical providers perceive and interact with birthing people, particularly those who are more likely to face discrimination on the institutional and individual levels. This awareness underlies intentional, informed support that centers the goals, values, and *experiences* of the birthing person. Certain types of support that function with the intention to mediate how others, particularly medical providers, relate to and interact with the birthing person mediate the presence of the birthing person as well. In the story that Lorie shared with me, she saw an opportunity to work within the relational network of the nurses to both help her client push and reframe the way that the nurses related to a birthing person that struggles to meet their clinical expectations.

Lorie also establishes her client as a “good” patient with a “good” labor within the local world of a hospital birth. Birthing people whose labor may not fit the ideal clinical timeline can be construed as “bad” patients with a “bad” labor by medical providers. Because of the pathologizing of Black bodies, this type of mediation resists the operationalization and ensuing

violence of moralizing judgements by practitioners that disproportionately harm Black birthing people. By challenging notions about good and bad patients, and good and bad labors, Lorie's support mediated the presence of her client as a compliant and unproblematic actor within the caregiving and receiving relationships in the birthing space.

Similarly, the reframing of uncomfortable and undesirable physical and emotional phenomena during labor extends into the interpersonal presence of the birthing person. Lorie described how she communicates about the labor progression for her clients who choose to have unmedicated births. Because nurses are often unfamiliar and uncomfortable with the progression of an unmedicated birth, Lorie often found herself "bragging on" her clients, "Like, 'Look how good she's doing!'" Lorie's intentional use of affirming language based on the experience of the both the client and the nurses with unmedicated birth frames the progression of labor as normal for the client, who may be unfamiliar with the sensations and experiences of an unmedicated birth, but also works to shift the perception of a birthing person choosing an unmedicated birth from a difficult, problem patient to one that can labor successfully within the caregiving parameters of a hospital birth.

Even the common strategy employed by doulas to support a client's decision-making ability during labor, encouraging them to discuss a potential intervention like being induced or having a C-section, with their partner without the presence of the attending physician, functions as a technology of presence. "And then I encourage the client to ask a lot of questions of the doctor, to process with their partner," Lorie told me. "I always create space for them...to ask questions." Diane agreed. By doing so, doulas alter the presence of their client in that

birthing space, from a patient passively receiving care to a person who has agency within the interpersonal relationships and environmental aspects of the birthing space.

These support techniques function as a technology of presence because they “(2) [render] one as perceptible and intelligible to others as a legitimate subject in local terms—a relational sense of ‘being there’” (Lester 2019, 65). Within the birthing space, doulas can extend their role in recognizing and validating the physical, emotional, and spiritual needs of their clients by making such concerns known within the interpersonal nature of caregiving and receiving. Additionally, by working and communicating with members of the medical care team in specific ways, doulas challenge the construction of their clients as problem or unruly patients, resisting the violence that certain clients can experience during a hospital birth.

### **Resisting Racialization through Presence**

Understanding how doulas interact with and mediate the presence of birthing people takes on particular importance when considering how the presence Black birthing people is rendered within hospital relational networks. Because presence emerges intersubjectively, an individual feeling present is inadequate for them to fully be present within relationships of caregiving and receiving: “the experience of presence is qualitatively dependent on others perceiving us and recognizing our right to exist...” (Lester 2019, 66). As discussed before, the racialized gaze reconfigures Black bodies and experiences to meet expectations for symptoms, diagnoses, and behaviors based in stereotypes and racism. Medical racism renders the sensations, experiences, and knowledge of Black bodies and individuals invisible, denying Black laboring individuals full presence in the space and relational networks of a hospital-based labor.

Lester (2019) stresses the reciprocal harms of relationally contested presence: "...if parts of who I am remain invisible to others or are denied the right to exist, it will become increasingly difficult for me to feel 'present' in them as well" (66). The pain, vulnerability, and fragility of Black obstetric patients, Black women in particular, are denied the right to exist in American biomedicine because of racist anthropology and science constructing, and academic and professional lineages perpetuating, the myth of the "obstetric hardiness" of Black women (Davis 2019, 94; Hoberman 2012, 130). Furthermore, the general denial of racism in medicine as a widespread and urgent issue can be understood as another mediator of intersubjective presence as well (Hoberman 2012, 7). Accumulated intra- and inter-generational trauma at the hands of a racist medical system and individual racist providers are rendered invisible by this denial, thus keeping the Black laboring individual from ever becoming "fully present" within patient-provider relationships. Thus, the role of a doula as a technology of presence must mediate the specific ways that racialization of Black bodies and medical racism deny and misconfigure the presence of Black laboring individuals.

Here, it is important to consider the implications of a White doula functioning as a technology of presence for a birthing person of color. The general lack of diversity within the doula community can result in the reproduction of the harms of racism, particularly anti-Black racism, and xenophobia within "support" provided. While the doulas that I spoke to and surveyed expressly indicated that they understood role of systemic and individual racism in the construction of the Black maternal health crisis, it is important to reckon with the limitations of White doulas in understanding and responding to potentially racist acts. These questions highlight the importance of promoting diversity within the doula work force and emphasize the

need to understand the impacts of potential doula-related policies on the recruitment, retention, and reimbursement of doulas of color.

In both survey and interview responses, the doulas I engaged with were generally aware of the role that racism plays, on a systemic and individual level, in the construction of the Black maternal and infant health crisis. While doulas recognized the role that they can play in individual births, relationships, and outcomes, the enormity of medical racism contextualized the perception of the impact of their work. Renie reflected:

The systemic inequalities, the racial inequalities... they're just so deep in society. How do we root that out? It can't just be one little person, even if you try....all a doula can do is be vigilant.

Doulas themselves recognize both the power of their work in challenging medical racism on the individual level and the limited ways in which such work impacts larger structures of racism. Political efforts to address the Black maternal health crisis increasingly uphold doulas, particularly doulas of color, as a key part of the solution. Efforts that fail to recognize the institutional level of racism in maternal health and instead focus on individual bias and discrimination create more “vigilant” individuals in an equally racist system.

Davis (2019) discussion of radical Black birth workers emphasizes the centrality of awareness of past and current harms against Black birthing bodies in the work of Black birth workers today (188). Not only does this motivate the ways in which these doulas support their clients, this recognition presents the reality of obstetric racism, legitimizing the embodied effects and manifestations of these harms to the laboring individual and within relationships in a hospital-based birth. Doula, then, can act to make racism “present” within these relationships by recognizing its embodied effects and drawing attention to its actions as a

player within patient-provider interactions. Given the culture of silence about racism amongst medical professionals, the act of manifesting racism as present within the space of a hospital birth radically challenges the individualizing narrative prevalent in discussions of and solutions for the Black maternal health crisis (Hoberman 2012, 6-8). Black birth workers that function *outside* of medical and governmental institutions can take on the radical role of observing and responding to racism in hospital spaces as outsiders to cultures of silence and individualization that characterize biomedical spaces.

### ***Tensions Between Care and Support***

Truly centering the goals of the birthing person becomes challenging when support comes into conflict with a doula's ethic of care. Consider the fact that Diane struggled to *support* a client because she cared about her and her newborn:

There was one postpartum client who was also a birth client. She was sixteen, in a really hard parenting spot. First baby. And so postpartum, it was really hard for me to not swoop in and try to do everything for her. They hardly had any food in the house, until I gave her community support resources, and she chose not to use them. It was really hard, like, to not want to try and fix all of it. And I can't. I can't do that unless I have her come to my house, which, you know, that's not possible.

While offering her client food and other necessities might be the caring thing to do, Diane recognized and respected the decision that her client made to refuse community support resources. Support, then, may not always align with our assumptions of what is best for an individual and their family. This is the exact principle that underlies support, regardless of a person's difficulty of adhering to it. Support is nuanced by the tensions between the individual's wishes and others' instincts, goals, and assumptions, such that supporting someone else is not always easy, and may not always feel "right."

Similarly, value alignment between a doula and their client can complicate support, as the lines between the goals and values of the birthing person and those of the doula become blurred. Joy described a time when she was supporting a client who was attempting a VBAC:

It was 4 o'clock in the morning...The chief resident came in and woke her up. She had just received her epidural half an hour prior to that. He woke her up and tried to convince her that her baby was in fetal distress, and that she was going to have to have a C-section again.

Joy suggested to the resident to use an internal fetal monitor to truly assess whether the fetus was in distress, and strongly encouraged her client and their partner to demand to see the attending physician before undergoing a C-section. While both Joy and her client had the same goal of avoiding a C-section if possible, by “interfering” with the delivery of care, Joy overstepped her role as a doula. Can (or should) support interfere with the delivery of medical care? In this particular situation, Joy’s background as a nurse and longitudinal relationship with her client may have lessened any potential harm that could have resulted from overstepping her professional boundaries as a doula. Ultimately, Joy’s client delivered a healthy baby vaginally, just as they had hoped. The doula scope of practice as defined by DONA explicitly says that “A health care provider...may not refer to themselves as a doula while providing services outside of a doula’s scope of practice...” (DONA, n.d.). While this may seem self-explanatory when it comes to certain obvious medical “services”, such as conducting ultrasounds or vaginal exams, the application of biomedical or institutional knowledge while working as a doula that was attained by being a health care provider does not fit neatly into this limitation of practice.

Similarly, the scope of practice recognizes that “the advocacy role does not include the doula speaking instead of the client or making decisions for the client” (DONA, n.d.). The line

between speaking instead of the client and speaking up about the client's pre-determined goals can become blurred, particularly in this case where the client had just received an epidural and was woken from their sleep. It may seem that in this case, Joy supported her client by leveraging her biomedical knowledge and speaking up for her client while they gained their bearings, but the question of the nature of Joy's overstep remains. What boundaries delineate support from care when the goals of the support person and the person being supported align? Do the rules defining the doula scope of practice limit or protect support?

Joy's ability to speak up (or over) her client and directly challenge the provider depended not only on her biomedical and institutional knowledge, but the fact that she was external to the formal hierarchies of the hospital space. If she was occupying her formal role of an L&D nurse, directly challenging the chief resident would have been seriously limited by her positionality within the hierarchies of hospitals. Only by functioning outside this hierarchy could she have taken such a bold stance. Though questions remain about how supportive Joy's actions truly were, such actions were only possible because she was a doula functioning outside formal institutional hierarchies.

A question emerges about the possibility of support and care overlapping within the birthing space, particularly by biomedical practitioners. The midwifery model of pregnancy, which posits that pregnancy and labor are healthy, normal physiological processes seems to allow some room for support within medical care. Miranda, a midwife at a large teaching hospital, described her practice and its philosophy in such a way that aligns it with support:

Whatever our patients want, as long as it's safe, we'll make it happen. Some people go in wanting an epidural, and that's totally fine. If that's what our patient wants, that's what we'll support them in. Some want an unmedicated birth, and that's okay, too.

Here, Miranda is clearly recognizing the importance of centering the goals, values, and experiences of her patients in determining a plan for, and when providing, their medical care, regardless of her personal beliefs towards either of those two choices, which is a clear element of support. Likewise, Miranda describes the “non-verbal communication” skills, (“touch”, “presence”) of midwives as extremely powerful in promoting positive birth experiences. Speaking a few words, such as “This is normal, you are safe,” can make “all the difference” for a patient. These actions, when taken by a doula, mediate the presence of a birthing person to themselves and within the relational networks of the birthing space. However, because Miranda as a midwife is the authority in giving care in the birthing space, these activities are being conducted, one might assume, almost exclusively for the experiential benefit of the birthing person.

Principles beyond that just of the patient guide the medical care that Miranda provides. “We support spontaneous labor. Allow the woman’s body to do what she’s supposed to be doing.” While many patients that choose to receive care from a midwife may share this value, the goal of the midwife may not necessarily align with that of the patient. Regardless, there may be room for support within the limitations of care. This may be how to best understand an ideal form for patient- or person- centered care.

### ***Conclusion***

I have argued that supportive relationships are distinct from caring relationships in that support is characterized by its active, informed nature that centers the experiences, values, and goals of the person being supported over those of the support person. While *care* may be well-

intentioned, its grounding in the values, routines, feelings, and goals of the person or institution that is giving care creates the opportunity for such care to become violent towards those being cared for. Support, though, imagined here in its ideal, cannot be violent because supportive activities would be sensitive to an individual's past traumas and experiences and would contribute to the realization of that individual's goals in a particular setting. Support mediating the presence of birthing people is one of the ways in which doula work is so radical. Challenging the disempowerment of birthing people in hospital spaces and resisting violent acts on behalf of providers are the ways in which support manifests in hospital-based births and creates better birth outcomes and experiences.

Doula support becomes possible because doulas are (generally) free from institutional pressures to prioritize certain values, goals, and outcomes. Institutionalization results in the exclusion of certain types of knowledge, people, and ways of discovery in favor of producing particular types of knowledge and outcomes that feed into the scientific and social authority of that institution (Bourdieu 1991, 6-8). Thus, the true nature of *support* can be challenged when doulas are incorporated into pre-existing institutions with their own values and goals without regard to how pressures to conform to those values can interfere with the radical nature of doula work.

Support also has the potential to disrupt institutional routines that render certain identities and experiences invisible. Drawing upon Lester's framework of technologies of presence, I argue that doulas intentionally "presence" their clients in ways that gently resist the harm that is enacted upon Black, Brown, Indigenous, or other marginalized individuals in a hospital setting. By mediating the presence of clients, the past experiences, and traumas of

birthing people of these backgrounds may become tangible within interpersonal networks of giving and receiving care in a hospital birth.

Understanding doula support as a technology of presence highlights the important connection between recognizing the experiential timeline of labor and the ways in which certain experiences and identities are rendered visible or invisible in a hospital-based birth. Elevating experiences, feelings, sensations, and embodied knowledge to be recognized within the relationships of caregiving and receiving resists the disempowerment of birthing people and recenters them in their birthing experience. Recognizing the experiential timeline of labor and then using such knowledge as a means of mediating presence depends upon doulas employing and trusting intuitive and embodied knowledge. Only by training, socializing, and practicing outside of formal medical institutions can such knowledge continue to thrive and be applied within biomedical spaces.

Support in practice is of course messy, confusing, and imperfect. In emotionally difficult work, reconciling one's emotional reaction to the suffering, traumas, and structural violence endured by others is a constant challenge. Experiencing such emotions while still striving to prioritize and respect the decisions of the person being supported can give rise to tensions between caring for that individual and supporting them. Similarly, the line between support and care can become blurred during advocacy, such as when a doula may speak up instead of the client when they believe the client's values are at risk of being compromised. Such tensions may not necessarily be resolved, and instead are characteristic of the emotionally intense nature of doula work and the ways in which doulas must conduct themselves within the limitations of the various roles and spaces they occupy.

The principles and practice of doula support could potentially inform the ways in which medical care for the pregnant and birthing can become more patient-centered. While there are many definitions of patient-centered care, the crux of each is that patients and providers are “partners”, and that health is addressed from a clinical, “emotional, mental, spiritual, social, and financial perspective” (NEJM Catalyst 2017). Expanding a provider’s understanding of health to include these other perspectives, along with supposedly equalizing the power differentials between patient and providers certainly moves patient-centered care closer towards support. Despite this, providers are still pressured to produce particular outcomes because of the profit-seeking motivations of American health care. Similarly, patient-centered care does little to uplift the forms of knowledge held by patients, and while patients and providers may be “partners”, the disparity in authoritative knowledge held between them undermines support emerging from this practice. In the Conclusion, I will discuss the opportunities for collaboration—and cooptation—between these concepts and the institutions that employ them.

## Conclusion

I used to have friends who were activists and went to protests against the Vietnam war. And they tried to get me to go to a protest, but I was a single mom and I had to raise my child. This guy told me a story about a river, and all the babies are being put in the baskets and sent down the river. He asked, 'What are you going to do, stop the baby baskets as they go by? Or go to the source and stop the baskets from being put in the river?' And I told him, 'I would try to grab as many baskets as I could.' These are my gifts here. You and your diplomatic skills, you can go and stop the baskets. But we need both. Maybe the little doulas are trying to help in the moment. But we need a system that supports moms in birth...And it was the wrong answer. And I felt bad about it. But over time, I realized that is my authentic answer. We need everyone to use their gifts. We need people down at the dam.

-Renie

In the face of a medical-industrial complex that dehumanizes birthing people, aggregates experiences into outcomes, and is violent towards birthing people of color, doulas can stand as a bulwark against such violence in individual labor rooms. In this thesis, I have explored some of the mechanisms through which doula work resists these forms of violence in hospital settings. In the first chapter, I sought to understand how doulas use different types of knowledge in the different spaces that they move among. Being able to synthesize biomedical, intuitive, ancestral, and other forms of knowledge into meaningful forms of connection is critical for doulas positioning themselves intentionally within the relationships that characterize a hospital-based birth. Doing so positions doulas to better engage with the emotions, sensations, and perceptions that define the inner world of the laboring individual without (if that is their goal) perceptibly interfering with caregiving in the birthing space. I argued that this connection to the experiential timeline of labor radically recenters the birthing person in a setting which seeks to disregard and degrade the embodied knowledge and experiences of birthing people.

Connection to the experiential timeline of labor depends upon doulas trusting intuitive and embodied knowledge—both their own and that of their clients. In chapter two, I framed such trust as essential to doula work and importantly, to the practice of *support*. Because support centers the goals, values, and experiences of the person being supported, trust in the body, feelings, emotions, intuition, and experiences of that person is necessary for the doula to be directed by those forms of knowledge. Likewise, the nature of support being working towards the goals of the person being supported, doula support once again radically prioritizes the birthing person within a homogenizing system. Importantly, doula support functions as a technology of presence. By mediating the way that the birthing person is connected to themselves and connected to the birthing space and its actors, doulas intentionally alter the ways in which some forms of violence are enacted during a hospital-based birth, from diminishing the importance (and existence of) the birthing person's embodied knowledge to stereotyping and discrimination of marginalized birthing people.

This thesis works to elucidate some of the underlying reasons as to why doula support is so powerful. Information provided by doulas is itself informed by the values, goals, and experiences of their client and is tailored to promote the achievement of the birthing person's, rather than an institution's, goals. Informational support can also presence birthing people within patient-provider relationships as informed, savvy patients with decision-making capacity. Emotional and physical support work to create meaningful connections between the birthing person and their inner and outer worlds, while validating the existence and importance of such experiences and connections.

Making the experiential timeline of labor tangible in the birthing space presences the subjectivity of the birthing person, creating pain, anxiety, fear, and other feelings as interactionable and recognizable characters in a hospital-based birth. The foundations and consequences of support are what I believe to be at the root of how doulas improve birth outcomes and experiences. Informational, emotional, and physical support are founded in forms of knowledge that challenge biomedical authority and are enacted through typically gentle forms of resistance that disrupt certain acts of violence at the site of caregiving, creating better birth outcomes and experiences.

As Renie recognized, creating systemic change such that violence at the site of birth is no longer an expected part of giving birth is a much more sustainable and effective method of creating better birth outcomes than standing “at the dam.” As she and the other doulas discussed the role of promoting midwife-attended labor as the standard and increasing access to home births in creating a better system for birthing people. However, how do we contend with the past and present structural violence experienced by Black and other birthing people of color when receiving pregnancy and birth-related care? As I discussed in the previous chapter, mediating presence takes on a new importance when birthing people are racialized within the processes of caregiving and receiving.

Doula support is an important part of, but nowhere near enough, to challenge the ways in which medical institutions are violent towards Black birthing people. Despite this, the legislative agendas that seek to address the maternal health crisis in the U.S bring doulas to the frontlines of improving outcomes on a systems-level. Thus, it is critical to understand the foundations of doula work in order to recognize the ways in which such legislation can impact

the conditions in which doula work has its greatest impact. With increased momentum to incorporate doulas into the legislative and political response to the maternal health crisis, it is important to critically look at the potential institutionalization of doulas within existing governmental and medical/hospital structures.

### ***Institutionalization and its Consequences***

Many doulas are already institutionalized through the process of becoming trained and certified by a particular professional organization. Indeed, as I discussed in Chapter One, the valorization of specific types of scientific knowledge that supports the existence and importance of doulas is characteristic of a knowledge-producing or capital-holding *institution* (Bourdieu 1991, 6-7). Unless a doula is truly a lay doula with no formal training or certification, a doula has undergone what Bourdieu calls a metamorphosis in order to be admitted to their particular institution (1991, 8). This metamorphosis involves the “tacit adherence to the stakes and rules of the game” on behalf of the new doula (Bourdieu 1991, 8). Meaning, that while the values of the training organization likely prioritize the principles of support that I highlighted earlier, in order for the institution to survive in the competition of producing and holding scientific capital, organizations must socialize their new members to act in accordance with the fundamental requirement of self-preservation, and in another way, self-promotion, in order to survive in Bourdieu’s conceptualization of the scientific playing field. And while I celebrated as radical the different types of knowledge that doulas employed, there are still forms of knowing that are excluded as heterodoxy in any institutional space (Bourdieu 1991, 9). Thus, it becomes clear that institutionalization can constrain a doula from employing and exercising particular

types of knowledge and skillsets, as well as promoting a form of practice that includes enacting and embodying institutional, along with client-defined, goals.

As doulas are increasingly brought into the mainstream political discussion about maternal and child health, there is the potential for doula work to become regulated as it is integrated into government programs. While it is reassuring that community-based doulas have been funded by Federal and State dollars in the past, some pieces of current proposed legislation seek to only extend Medicaid benefits to certified doulas, which can exclude lay doulas with experiential, rather than professional, knowledge (H.R. 2751, 2019). Private doula training can cost up to thousands of dollars, with certification and recertification costs also ranging up to the hundreds of dollars (Freutel 2021). Thus, low-income, Black, Brown, and Indigenous doulas are disproportionately impacted by the high costs of professionalization and are then less likely to be able to participate in state-sponsored programs (Ellmann 2020). This harms both the doula and birthing people, as fewer birth workers of color are able to benefit from public dollars. Likewise, birthing people of color are denied access to working with doulas of similar backgrounds to their own. Though the sample of doulas that I engaged with was majority white, the benefits of Black doulas serving Black clients have been detailed before (Davis 2019). Certification regulations that disproportionately exclude low-income, Black, Brown, and Indigenous doulas from serving their communities synergistically create cycles of exclusion and harm in these communities.

The conversations surrounding the regulation of doula services are reminiscent of congressional and state-level regulation of midwifery practice. All states license nurse-midwives, about half license direct entry midwives, and a few license CPMs. In states where

direct-entry midwives are not licensed, there is simply no regulation, while in Georgia, direct-entry midwives practice illegally. Hawai'i does exempt traditional healers performing prenatal and birth care from the need from licensure (Midwives Alliance of North America, n.d.). State level regulation controls the types of births that midwives may attend and may require physician oversight to their practice (Ellman 2020). Such practices both limit the scope and autonomy of midwife practice and exclude those unable to gain licensure for various reasons. Lay midwives without access to institutional means of gaining recognition for their skills and knowledge are excluded from the existing and proposed legislation (H.R.2751) that seeks to provide Medicaid reimbursement for midwifery services (Midwives Alliance of North America, n.d.).

Tension exists between midwives that believe operating outside of the purview of government and medical regulation is best, while others argue that working outside of medical settings is damaging to their practice (Ellmann 2020). What was agreed upon though, was the need "for preserving the autonomy of midwifery care" (Ellman 2020). While the ramifications of being excluded from the medical and state system are far different for doulas than they are for midwives, this preservation of autonomy comes into question with the current excitement to integrate doula services into Medicaid.

Additionally, much of the academic and political discourse regarding the integration of doulas into Medicaid coverage is in the context of cutting pregnancy-associated medical costs (Kozhimannil et al, 2013). Inherent to these proposals of cost-cutting measures are extremely low rates of doula reimbursement, ranging only in the arena of a couple hundred dollars for the spectrum of services, including labor support, that is provided (Ellmann 2020). Such low

reimbursement rates are unsustainable for doulas trying to make a living, limiting the quality of services that they can provide and once again discouraging and excluding low income and BIPOC doulas from being integrated into these services.

Furthermore, assessing the intentions and goals of this institutionalization reveals the concerning fact that *lowering the cost* to the government of pregnancy, labor, and postpartum care contributes heavily to the motivation to integrate doula services into Medicaid. How does this institutional goal alter the ways in doulas would be trained, treated, and allowed to practice? Increasing access to doula services for low-income and birthing people of color is absolutely necessary; reimbursement through Medicaid is just one way to do so. However, it is important that policymakers at the federal and state level alike remember that the purpose of a doula is to support their *client* in any way that they can, not only in such a way that results in lower medical costs to the state.

It is important that lawmakers and pre-existing community-based birth work organizations critically look at the potential consequences of how their state's Medicaid-reimbursement policies would affect who can be reimbursed, a doula's scope of practice, and the sustainability of reimbursement rates. Instead, government funds for pre-existing community-based birth organizations so that they can expand their scope and serve birthing people who may not have previously been able to afford doula services could remedy some of the consequences of institutionalization that Medicaid reimbursement may pose (Ellmann 2020).

For example, the By My Side doula program that was discussed in the introduction combines the scope of practice of private doulas with community-based birth workers and case

management. Funded by the New York City Department of Health and Mental Hygiene and the U.S Department of Health and Human Services, this program connects Black birthing people to doula services in Brooklyn (Thomas et al, 2017). That said, this program does depend on some volunteer work. Expanding funding could recruit more doulas and extend services to more birthing people in need. The positive experiences of both doulas and clients in the program, though, highlights the importance of strengthening community-based organizations so that they can build upon their connections and impact (Thomas et al. 2017, 563).

Similarly, it is important to interrogate hospitals themselves training and hiring doulas to serve their patients. Renie had been a volunteer doula in the past, serving birthing people in active labor at a hospital; she proudly shared how she was able to support those clients despite the lack of a pre-existing relationship. Likewise, Miranda, the midwife I spoke to, greatly valued the work and impact of volunteer doulas within her hospital system. I do not seek to minimize the value of those experiences and the impact of such incredible work. Hospital volunteer doulas choose to spend long hours doing emotionally challenging work for free. A doula being available, for free, for a birthing person that desires such services is exceptional given the current state of access to birth workers in this country. That being said, autonomy in medical spaces was essential to the practice of all of the doulas that I spoke to, and a commonly expressed sentiment among radical birth workers in general (Ellmann 2020). Separation from the hierarchies and values that characterize medical spaces allow doulas to critically and intentionally interact with those spaces and presence clients, aware of how such hierarchies and values can impact their birthing experience. Understanding how authority is constructed in

a hospital space without being beholden to those systems is critical to the powerful ways in which doulas are able to navigate and disrupt the processes that lead to poor birth experiences.

Additionally, support during pregnancy is a key aspect of doula services. Helping clients navigate their emotions, maternal care provider appointments, and the various birthing options that they have is an important part of supporting a client and centering their goals and values in their birthing experience. Connection to the values, goals, and experiences of the client, essential for support, often began during pregnancy. While on-site doula services certainly can and do improve birthing experiences, support during pregnancy and an existing understanding of the client's goals, values, and experiences define support and maximize the power of the doula-client relationship.

Bourdieu's description of the process of being admitted to a scientific institution highlights the mechanisms the foundation of the power of doula work can be threatened. The "metamorphosis" and "tacit adherence to the stakes and rules of the game" that doulas would undergo could limit their ability to utilize and uplift alternative knowledge systems in a biomedical space. Additionally, tacit adherence to the goals of an outside institution can radically shift the goals that must be enacted and embodied by doulas from those of their clients to those of the institution that they are a part of (Bourdieu 1991, 8). Intrinsic to biomedical institutions in the United States are structural racism, hierarchies of power, and the devaluing of patients from low-income backgrounds. How would these larger forces and trends manifest in the ways in which doulas are allowed to interact with clients and providers? How would doulas continue to play their role of critically assessing birth practices in these institutions?

While hospital-based doulas play an important role in improving birth experiences and outcomes, maintaining the autonomy of doula work from medical institutions while improving collaboration with providers, midwives, and nurses can protect both doula work and improve experiences for birthing people. In this thesis, I sought to understand *why* autonomy is so critical in doula work. Ultimately, doula autonomy allows them to engage with and employ marginalized ways of knowing to form meaningful, potent, and radical connections with birthing people and their embodied, emotional, spiritual experiences and sensations. Trust in these connections and the knowledge of their clients underlies support, practices which can resist the violence of biomedical care for pregnant people. The threat that institutionalization poses to these ways of knowing and to support makes it clear that while increasing access to doulas, particularly for low-income and birthing people of color is imperative, collaboration rather than co-optation must be the principle that drives the future of intentional integration of doulas into hospital routines.

### ***Legislative Initiatives to Expand Access to Doula Services***

The maternal health crisis, and the Black maternal health crisis in particular, has come to the forefront of the legislative agendas in states and at the federal level due in part to the COVID-19 pandemic (Olllove 2021). On April 13<sup>th</sup>, 2021, President Joe Biden declared April 11<sup>th</sup>-17<sup>th</sup>, 2021, as Black Maternal Health Week (Biden 2021). In his statement, Biden committed to pursuing policies to providing “comprehensive, holistic maternal health care”, to “grow and diversify the perinatal workforce”, and to “invest in community-based organizations” as vital ways of addressing the crisis (2021). Likewise, the Centers for Disease Control and Prevention

launched the “HEAR HER” campaign in 2020 to raise awareness about maternal mortality and severe maternal morbidity, particularly during the postpartum period (“Hear Her: CDC” 2020).

Due to the robust scientific evidence that highlights the role of doulas in improving birth outcomes and experiences, there has been an increased effort to fund doula access for low-income birthing people through community-based programs and Medicaid. Oregon, Minnesota, and Indiana have included some forms of doula support under their Medicaid programs, and New York State has implemented a pilot program of covering some forms of doula support for Medicaid recipients (Gebel and Hodin 2020).

There have been significant advocacy efforts to support pieces of legislation in support Medicaid coverage of doulas or other funding programs to increase access to doulas in multiple states and Washington D.C. (Gebel and Hodin 2020). On the Federal Level, five bills have been proposed that include language that funds doula training and use by Medicaid recipients (Gebel and Hodin 2020). Expanding access to doula support is a critical, though not the only, component of addressing the Black maternal health crisis. I will analyze five proposed pieces of legislation as to their potential effect upon the expansion of access to doula services and the potential consequences of specific stipulations of the bills on the independence and scope of doula practice. By doing so, I demonstrate the newfound political push, and some of its critiques, to institutionalize doulas as a part of addressing maternal health disparities in the U.S.

#### S. 1314: MOMMIES Act:

This act would extend Medicaid and CHIP benefits for low-income pregnant and postpartum people from 60 days following birth to a full year. Importantly, the proposed legislation directs grants to be provided for states to expand the “maternity care home model”

for eligible pregnant people. The goal of this project includes “integration of perinatal support services, including...doulas...into health care entities and organizations” and should be designed and implemented through consultation with “community-based health care professionals, including doulas...” (S. 1314, 2019). The bill also allows grants awarded to states to be used to fund trainings for doulas, assign eligible individuals a “traditional or community-based doula” and fund “continuous labor support” (S. 1314, 2019).

Additionally, Section 5 of the bill outlines the necessary reporting a state must produce regarding the state of doula access for their Medicaid recipients. Such reporting must include consultation with doulas from, and doula organizations representing “underserved communities, particularly communities of color, and communities facing linguistic or cultural barriers” (S. 1314, 2019). The inclusion of community-based doulas in this legislation partially remedies some of the concerns regarding the institutionalization of doulas that may arise from legislation, however it is important to note that the creation and implementation of these maternity care homes is under the jurisdiction of individual states, meaning that wide variability can exist between states in terms of which groups of birthing people will have access to particular types of services.

#### H.R. 2602: Healthy MOMMIES Act

This bill is very similar to S. 1314 in its expansion of Medicaid benefits both temporally and in terms of services. One noticeable difference is that states may use federal grant money to provide “financial incentives” for “community-based doulas” to participate in state maternity care homes (H.R. 2602, 2019). The care coordinator assigned to individuals participating in these programs may be a doula. Such programs must also ensure that care be “patient-led” and

ensure that those providing care must be trained in a variety of topics, including the “reproductive and birth justice frameworks” (H.R. 2602, 2019). Much of the language of this bill reflects the language of S.1314 mentioned above, however there does appear to be an increased focus on promoting the sustainability of the community-based doula model within these maternity care homes.

HR 2751: Mamas First Act:

This bill seeks to include doula and midwifery services in Medicaid coverage. This bill defines a doula as having to be “certified by an organization, which has been established for not less than five years and which requires the completion of continuing education to maintain such certification...; and maintains such certification by completing such required continuing education” (H.R.2751, 2019). Such requirements clearly exclude lay doulas and those unable to continue to afford the costs of continuing education classes and certification/administration fees from supporting Medicaid recipients. While there are valid concerns about the regulation of doula knowledge and skillset in the context of government funding, the high barrier to entry proposed by this bill, and the typically low rates of Medicaid reimbursement for participating doulas raises some serious concerns.

HR 3344: Opportunities to Support Mothers and Deliver Children Act:

This bill seeks to appropriate funds for the training of doulas and other health professions in states that recognize doulas (and midwives) as health care providers and pays for such services (H.R. 3344, 2019).

S1600: Maternal CARE Act:

Proposed by Vice President Kamala Harris, this bill discusses the maternity care home model (which includes doulas in its creation and implementation) as well as appropriates funds for implicit bias training for doulas (S.1600, 2019).

As I have argued, some of the most powerful mechanisms through which doulas can radically shift birthing environments and support birthing people depends on them being non-institutional actors. When considering the integration of doula services into pre-existing governmental and medical structures, the voices of local, community-based doulas and the clients that they serve must be centered so that the autonomy of their practice can be preserved. Likewise, grant funding for programs like By My Side can be a model for other states and cities that seek to fund pre-existing community-based doula networks. Expanding the capacity of strong, independent programs so that they can serve more people should be a legislative priority. Supporting community-led formation of autonomous doula programs where they do not already exist can protect new doula organizations from the institutional goals of biopolitical regimes. Ultimately, expanding doula access is only one part of a much more systemic and radical change that needs to occur in order to create political, economic, social, and health systemics that actually support the health of Black and marginalized birthing people and children.

### ***Patient-Centered Care***

While care and support are fundamentally different, care providers can benefit from working with and learning from doulas while potentially incorporating support into their practice as well. The patient-centered model of care represents a new way of involving patients in their care. Shared decision-making, structural and cultural competency, and respect distinguish patient-centered care from traditional models of medical care delivery (NEJM Catalyst 2017). In the context of labor and delivery, the American College of Obstetricians and Gynecologists conceptualizes patient-centered care to involve empathetic communication and listening, shared decision-making, and teamwork (ACOG 2011). Patient-centered care complements, but does not replace, doula support for birthing people. First, while patient-centered care includes continuity of care between providers and sites, doula support extends between the medical and the home environments and encompasses addressing a client's non-medical concern in these various spaces (NEJM Catalyst 2017). Additionally, the patient-centered care model requires the alignment of the health care system with patient goals and vision (NEJM Catalyst 2017).

The forces that define the priorities of the health care system are unlikely to make room for patient-centered goals in their agenda of maximizing profits. Labor and delivery units being chronically understaffed with overworked providers does not create an environment conducive to the tenets of patient-centered care. Indeed, doulas and midwife alike spoke of the importance of doulas in filling that gap in communication and compassion:

We're a really busy practice. We'd love to be in patients' rooms all the time... but if there are four people in labor, we can't do that!

-Miranda

I do think a lot of the time, the nurses are glad that I'm there because they don't have to worry about the client, the 'patient in room 2' because they can spend more time with the patients in rooms 3, 4, 5 because the patient in room 2 has someone with them.

-Lorie

It is clear that in the current system, doula work fills an important gap between empathy and compassion that birthing people desire from providers and the amount that providers are able to give due to the various structural constraints placed on them. Understaffed, overworked labor and delivery rooms are more likely to be filled by low-income, publicly insured birthing people at public hospitals. Thus, while the new push to embrace patient-centered care is a move in the right direction, access to compassionate, whole-person care will be stratified by pre-existing systems of health inequity. Accessible doula services continue to be key in promoting better birth outcomes and experiences for Black and marginalized birthing people on an individual level even as patient-centered care expands. Finally, doula support can result in birthing people choosing not to give birth in a hospital by helping birthing people navigate care options, including birthing center and home birth. It is unlikely that the informational "support" and shared decision-making in the patient-centered care model would promote such outcomes even if that was truly the patient's goals due to the institutional pressure to monopolize medical authority and insurance money.

Patient-centered care cannot take the place of doula support—both are necessary to create more positive birth outcomes and experiences. Collaboration between hospitals and community-based doula organizations can create doula-friendly policies and practices, both in birth and in prenatal care, so that doulas can more seamlessly integrate into the birthing person's team during all stages of care. Educating providers about the role of doulas and their

scope of practice can improve teamwork and reduce animosity within the birthing space. Addressing stereotypes and stigmas about doulas—and birthing people that use their services—can lead to better birthing space dynamics and more respectful communication between providers, doulas, and birthing people.

Support is a radical way of challenging institutional routines and capitalist priorities in a medical system that disproportionately neglects and harms Black and other marginalized birthing people. While I explored support as a concept in general, and some of the doulas that I spoke to specifically worked with low-income or birthing people of color, more research must focus specifically on the important work of BIPOC birth workers. Public officials that seek to improve the disparately poor birth outcomes in these communities must understand the techniques, philosophies, and actions that BIPOC birth workers employ so that policy and programming supports, rather than limits, the work that activists are already engaging in.

These perspectives must be centered in the efforts to reimagine what pregnancy, birth, and the postpartum period looks like for Black and other marginalized birthing people. In this thesis, I have worked to identify the mechanisms and processes through which doula support *can* be so impactful: built upon trust in embodied, ancestral, and other forms of knowledge, doula *support* mediates the presence of birthing people in hospital spaces and can resist particular acts of violence to create better birth outcomes. The power of doula work must be recognized alongside the need for structural change as public officials, medical professionals, and community leaders alike reckon with the state of maternal and child health in the United States.

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