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Birthing Alone

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Abstract

Throughout the COVID-19 pandemic, hospitals implemented restrictive visitor policies that have prevented many pregnant people from giving birth with their chosen support people. For some, this meant foregoing labor and delivery support by a birth doula, someone who serves in a nonclinical role and provides emotional, physical, and informational support to birthing people. Given that continuous labor support such as the care provided by doulas is associated with fewer cesareans and other interventions, less need for pain medication, and shorter labors, the promotion of doula care is a promising strategy to ease the maternal health crisis and, in particular, shrink the perinatal health equity gap, as reflected in a pregnancy-related mortality rate for Black women that is three to four times higher than for White women.

As COVID-19 case rates declined and hospitals relaxed their restrictions, some doulas found themselves subject to new hospital credentialing requirements in order to attend births, even though they serve in nonclinical roles and are hired by the

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birthing person rather than the hospital. This Article explores the often-contested relationship between doulas and hospitals, and between doulas and hospital-based perinatal care providers, against the historical backdrop of other restrictions on birthing companions since birth shifted from the home to the hospital around the turn of the twentieth century. It details the important role doulas play in promoting good perinatal health outcomes and considers why many hospitals and healthcare providers perceive doulas as a threat rather than as a source of value in the delivery room, which results in strategies to restrict doulas through formal and informal mechanisms. This Article suggests that hostility to doulas and restrictions on birth support reflect central qualities of mainstream perinatal care, such as liability-driven decision-making, nonadherence to evidence-based medicine, medical paternalism, and fear, all of which interfere with efforts to improve health outcomes in the midst of a maternal health crisis that disproportionately burdens communities of color.

Ultimately, this Article argues that doula credentialing is a regulatory mismatch that should be abandoned by hospitals as misguided and counterproductive, and instead identifies public and private policy changes, along with related advocacy strategies, that would provide appropriate recognition of doulas within the perinatal healthcare system and serve both patient and provider interests while protecting the autonomy of doulas to operate within their scope of practice. Increased attention to the United States' maternal health crisis and the opportunity to advance healthcare reforms that incorporate lessons from the pandemic make this a critical time to prevent the widespread adoption of credentialing requirements before they become the default norm, and instead to pursue investment in growing the doula model as an efficient and effective means to improve childbirth experiences and reduce the stark racial inequities in perinatal health outcomes.

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INTRODUCTION

As COVID-19 hit the United States in early 2020, many hospitals adopted restrictive visitor policies to curb the spread of the virus and minimize risk to healthcare providers and patients.[1] For people[2] who went into labor as hospitals began to fill with seriously ill patients, these restrictions often meant they could be accompanied during childbirth by one person only or, in some instances, were forced to deliver without the support of any loved ones.[3] When one support person was permitted, that person was often allowed on the condition that they would not be able to leave and subsequently return—once inside, it would

1. *See* Irin Carmon, *More Hospitals Are Banning Partners from Delivery Rooms*, THE CUT (Mar. 23, 2020), https://perma.cc/Y5TY-8GBP; Emily Bobrow, *A Chaotic Week for Pregnant Women in New York City*, NEW YORKER (Apr. 1, 2020), https://perma.cc/X7UY-JLDT; Wendy Ruderman, *Fleeing Coronavirus in NYC, Pregnant Women Head to Philly Area But Struggle to Find Prenatal Care*, PHILA. INQUIRER (Apr. 2, 2020), https://perma.cc/MUC9-QNYW; *see also* Elizabeth Kukura, *Seeking Safety While Giving Birth During the Pandemic*, 14 ST. LOUIS U. J. HEALTH L. & POL'Y 279, 292–98 (2021) [hereinafter Kukura, *Seeking Safety*] (discussing companion bans that prompted pregnant people to pursue community birth instead of hospital birth during the pandemic).

2. In certain places, this Article refers to people seeking pregnancy and childbirth care as women, but it is important to recognize that some men and nonbinary people also experience pregnancy and childbirth. *See* Robin Marantz Henig, *Transgender Men Who Become Pregnant Face Social, Health Challenges*, NPR (Nov. 7, 2014, 3:53 PM), https://perma.cc/7HHP-68CH; Heidi Moseson et al., *The Imperative for Transgender and Gender Nonbinary Inclusion: Beyond Women's Health*, 135 OBSTETRICS & GYNECOLOGY 1059, 1061–62 (2020). More research is needed on the experiences of transgender individuals seeking perinatal care in mainstream healthcare institutions. *See* Juno Obedin-Maliver & Harvey J. Makadon, *Transgender Men and Pregnancy*, 9 OBSTETRIC MED. 4, 5 (2016); Elizabeth Kukura, *Reconceiving Reproductive Health Systems: Caring for Trans, Nonbinary, and Gender-Expansive People During Pregnancy and Childbirth*, 50 J. L. MED & ETHICS 471 (forthcoming 2022). For accuracy, this Article will use the terms "pregnant people" or "birthing people" in general discussion and "women" when discussing particular examples, explicitly gendered aspects of childbirth-related care, or research involving only women, even though the research findings may be applicable to all pregnant people.

3. *See, e.g.*, Nofar Yakovi Gan-Or, *Going Solo: The Law and Ethics of Childbirth During the COVID-19 Pandemic*, J.L. & BIOSCIENCES, Jan.–June 2020, at 1, 2 ("[A]t least two leading hospital networks in New York City decided to bar spouses, partners, and other family members, as well as professional support people such as doulas, from their delivery rooms.").

be for the duration of labor and delivery.[4] Some hospitals required support people to depart immediately after the delivery, leaving the new parent to begin the recovery process and care for a newborn alone until they were ready for discharge.[5] Adoption of these policies generally left birthing people without the support of doulas with whom they had worked to prepare in advance of delivery,[6] and forced others to choose between a partner, mother, sister, or best friend.[7] A birth doula is someone "trained to provide non-clinical emotional, physical and informational support for people before, during, and after labor and birth."[8] Research shows that continuous

4. *See, e.g.*, Carmon, *supra* note 1 (describing a policy implemented by twenty-three New York-area hospitals preventing "return visitation" after a support person leaves the building).

5. *See, e.g.*, Sonja Sharp, *Pregnant Women Forced to Get Creative as Coronavirus Bears Down on L.A. Hospitals*, L.A. TIMES (Apr. 1, 2020), https://perma.cc/CZ36-TKLG ("Once the baby is born, new families have just minutes together before the father or partner is asked to leave.").

6. *See, e.g.*, *id.* (recounting the experience of one mother who had originally planned to have her doctor, husband, and doula present but would not be able to have them with her due to restricted visitation policies).

7. *See, e.g.*, Carmon, *supra* note 1 (describing a hospital policy prohibiting labor and delivery patients from receiving rotating visitors).

8. ASTEIR BEY ET AL., ADVANCING BIRTH JUSTICE: COMMUNITY-BASED DOULA MODELS AS A STANDARD OF CARE FOR ENDING RACIAL DISPARITIES 5 (2019), https://perma.cc/HT9F-2F4V (PDF); *see also What Is a Doula?*, DONA INT'L, https://perma.cc/AN5J-N6NK (defining doula as "a trained professional who provides continuous physical, emotional and informational support to their client before, during and shortly after childbirth to help them achieve the healthiest, most satisfying experience possible"). "The word 'doula' comes from ancient Greek, meaning 'a woman who serves.'" Coburn Dukehart, *Doulas: Exploring a Tradition of Support*, NPR (July 14, 2011, 10:40 AM), https://perma.cc/79HT-4CY5. There is variation in how and when doulas provide support throughout pregnancy, childbirth, and the postpartum period. *See* BEY ET AL., *supra*, at 5. Some doulas meet with their pregnant clients one or multiple times during pregnancy, in addition to providing emotional support and newborn feeding assistance early in the postpartum period, while other doulas only provide care during labor and delivery. *See id.* at 12–14. Doula standards of practice generally provide that doulas do not prescribe treatment and do not perform any clinical tasks, such as taking blood pressure or temperature, checking fetal heart tones, or performing vaginal examinations. *See* DONA INT'L, STANDARDS OF PRACTICE: BIRTH DOULA, I.A–B (2017), https://perma.cc/RR7R-XZRE (PDF). Some doulas identify as full-spectrum doulas, radical doulas, or abortion doulas, providing support for experiences across the reproductive cycle, including abortion, miscarriage, and stillbirth. *See* MARY MAHONEY & LAUREN MITCHELL, THE DOULAS: RADICAL CARE FOR PREGNANT PEOPLE, at xx (2016) ("This brand of doula care typically

labor support like that provided by a doula is associated with improved perinatal health outcomes and positive birth experiences.[9]

Pregnant people and birth advocates protested these policy changes and won reversal of the most restrictive rules in some jurisdictions,[10] in several instances by executive order.[11] Many professional birth doulas began providing virtual support to their clients—not a replacement for hands-on assistance during painful contractions or the intimate emotional support that studies have shown reduces pain and shortens the duration of labor, but a meaningful attempt to adapt to the immediate global health crisis.[12] As case rates declined temporarily over the summer of 2020, many hospitals eased their visitor policies and permitted doulas to return to the hospital; however, as subsequent waves of increased COVID-19 case rates prompted hospitals to re-implement stricter protocols, policies regarding in-person doula support continued to fluctuate in many locales.[13]

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consists of physical, emotional, educational, and spiritual support and almost always involves being present during an abortion or birth."). Those who work as full-spectrum or radical doulas may incorporate an explicitly political critique into their work and prioritize providing free or low-cost services to poor and marginalized birthing people. *See* MIRIAM ZOILA PÉREZ, THE RADICAL DOULA GUIDE: A POLITICAL PRIMER FOR FULL-SPECTRUM PREGNANCY AND CHILDBIRTH SUPPORT 7 (2012). This Article will focus on birth doula support, although the broader themes discussed below are relevant to various kinds of doula care.

9. *See infra* Part III.A.

10. *See, e.g.*, Margaret Rodeghier, *How Michigan Doulas Secured Their Position in Hospitals During COVID19 Pandemic*, GROSSE POINT DOULA (Mar. 17, 2020), https://perma.cc/6ZRT-M8GY (last updated Mar. 19, 2020); Katie Van Syckle & Christina Caron, *'Women Will Not Be Forced to Be Alone When They Are Giving Birth'*, N.Y. TIMES (Mar. 28, 2020), https://perma.cc/L2GJ-BVLP.

11. *See, e.g., Executive Order 2020-37 FAQS (No Longer Effective)*, MICH. DEP'T OF HEALTH & HUM. SERVS., https://perma.cc/6UVU-KEDZ ("[A] partner and doula may accompany a laboring mother . . . ."); N.Y. Exec. Order No. 202.12 (Mar. 28, 2020), https://perma.cc/3LDM-9ZNR (PDF) (requiring hospitals to "permit the attendance of one support person who does not have a fever at the time of labor/delivery").

12. *See* Gray Chapman, *'A Lifeline': The Doulas Guiding Clients Through Childbirth—From a Distance*, THE GUARDIAN (Apr. 22, 2020, 1:00 PM), https://perma.cc/3PD3-FWB5.

13. *See, e.g.*, Bianca Marcof, *Accusations Launched Against Jackson Memorial Hospital by Southern Birth Justice Network*, MIAMI TIMES (Nov. 23, 2021), https://perma.cc/9UWL-D322 (last updated Nov. 24, 2021) (discussing

Furthermore, in some jurisdictions, doulas have found that they are now required to apply for a hospital credential using the same process that applies to hospital vendors.[14]

While credentialing for doulas has been debated in recent years, with some hospitals having already adopted this requirement prior to the COVID-19 pandemic, birth advocacy organizations have expressed concern about the increasingly widespread adoption of formal barriers to doula support.[15] Although doulas are not hospital employees or contractors, credentialing requirements create a status for doulas that blurs these lines, shifting focus away from the relationship between a doula and the birthing person who hired her and onto the relationship between a doula and the hospital where the birthing person seeks care.[16] Birth advocates fear that, while hospitals justify these policies as COVID-19 prevention measures, new doula requirements instituted by hospitals will persist even after the threat posed by COVID-19 wanes as healthcare providers continue to perceive doulas as a professional threat and seek to exercise control over the support they provide to hospital patients. In particular, advocates are concerned that credentialing requirements will interfere with the promotion of doula care as part of broader efforts to reduce the staggering Black maternal mortality rate in the United States and to improve the birthing experiences and outcomes of all pregnant people.[17]

In fact, restrictions on birthing companions are not a new development, but rather have been a feature of modern childbirth in the United States ever since the primary location

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Jackson Memorial Hospital's policy of limiting birthing patients to one support person even as "the pandemic has been winding down [and] many hospitals have eased their restrictive policies").

14. *See, e.g.*, Michelle Boudin, *Novant Health's New Policy Requires Doulas to Register with the Hospital*, WCNC CHARLOTTE (Mar. 10, 2021), https://perma.cc/9VHB-E23J.

15. *See* Demetria Clark, *Doula Access Letter for Medical Facilities*, BIRTH ARTS INT'L (July 10, 2020), https://perma.cc/J93Q-WNQL; Amy Gilliland, *Hospital Agreements: The Wrong Solution for the Right Problem*, DOULAING THE DOULA (June 27, 2016), https://perma.cc/3XYW-8FT5.

16. *See* Boudin, *supra* note 14 (describing the concern of patients that "doula[s] would have to answer to the hospital first and [the patient] second").

17. *See* Christine Hernandez, *Should We Be Making It Harder for Doulas to Help?*, ROMPER (July 20, 2019), https://perma.cc/YMH4-U5RS.

for childbirth moved from the home to the hospital around the turn of the twentieth century. This Article builds on that history to explore the often-contested relationship between doulas and hospitals, and between doulas and hospital-based perinatal care providers. Using the COVID-19 pandemic as a lens, this Article examines the concept of birth support as contested terrain in mainstream perinatal care, shedding light on why a seemingly shared value—that birthing people should receive the care they need to arrive at the end of the childbirth experience emotionally and physically well—provokes disagreement and resistance in its implementation. Specifically, this Article identifies the important role that doulas play in promoting good perinatal outcomes[18] and explores why many hospitals and healthcare providers perceive doulas as a threat rather than as a source of value in the delivery room, pursuing strategies to restrict doulas through formal and informal mechanisms.[19] It suggests that hostility to doulas and restrictions on birth support reflect central qualities of mainstream perinatal care, such as liability-driven decision-making, the rejection of evidence-based medicine, medical paternalism, and fear, all of which interfere with efforts to improve health outcomes in the midst of a maternal health crisis in the United States.[20]

Although women have supported other women in childbirth throughout history, the modern conception of a birth doula dates to the 1980s, when a group of researchers and advocates whose work focused on promoting the benefits of continuous labor support chose the word "doula"—from the Greek work for "woman servant"—to describe a person who serves birthing people and their families.[21] As the term has become more widely understood, the concept has been adopted to describe similar support roles involving individualized provision of nonjudgmental support for significant life events beyond birth, including abortion, infertility and assisted reproduction, pregnancy loss, adoption, and death.[22] Doulas who provide

18. *See infra* Part II.

19. *See infra* Part IV.A.

20. *See infra* Part IV.B.

21. *See DONA International History*, DONA INT'L, https://perma.cc/2ZDR-SESB.

22. *See, e.g.*, *What Is an End-of-Life Doula?*, INT'L END OF LIFE DOULA ASS'N., https://perma.cc/KJV7-PHEC (defining an end-of-life doula as someone

support across the full reproductive lifespan—including abortion, infertility, surrogacy, pregnancy loss, adoption, and postpartum care—often refer to themselves as "full-spectrum" doulas.[23] Though this Article focuses on birth doulas, the fact that the concept of doula support has expanded in scope is important context for understanding the model of care and its growing salience for people looking outside traditional healthcare institutions to have their care needs met.

This Article makes an important contribution to the legal scholarly literature on healthcare regulation, which has devoted virtually no attention to the legal status of doulas or the positive impact of the doula model on perinatal health care.[24] It also adds to the growing law review literature on health equity, offering a critique of doula credentialing as regulation that interferes with efforts to close the perinatal health equity gap that

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who "guides a person who is transitioning to death and their loved ones through the dying process").

23. *See, e.g.*, *Doula Support Services*, FULL SPECTRUM DOULA CARE, https://perma.cc/R8W2-FCMB.

24. A LexisNexis search for "doula" yields a small handful of law review articles containing substantive discussion of doulas, most of which pertains to prison doula programs that provide support for pregnant and birthing women who are incarcerated. *See, e.g.*, Mahnoor Yunis, *The Challenges in Health Care for Pregnant Women in U.S. Correctional Institutions*, 19 HASTINGS RACE & POVERTY L.J. 125, 148–49 (2021) (discussing a study of the Minnesota Doula Prison Project that reported benefits of doula support for incarcerated pregnant women); Richard C. Boldt & Eleanor T. Chung, *Community Health Workers and Behavioral Health Care*, 23 J. HEALTH CARE L. & POL'Y 1, 54–55 (2020) (noting that Oregon's Traditional Health Worker Commission must include a doula representative); Lauren Kuhlik & Carolyn Sufrin, *Pregnancy, Systematic Disregard and Degradation, and Carceral Institutions*, 14 HARV. L. & POL'Y REV. 417, 447 (2020) (discussing state and county prison doula programs for incarcerated pregnant women); Khiara M. Bridges, *Racial Disparities in Maternal Mortality*, 95 N.Y.U. L. REV. 1229, 1313–14 (2020) (discussing benefits of doula support and Medicaid coverage of doulas); Robin Levi et al., *Creating the "Bad Mother": How the U.S. Approach to Pregnancy in Prisons Violates the Right to Be a Mother*, 18 UCLA WOMEN'S L.J. 1, 34–36, 45, 53 (2010) (describing the work of volunteer prison doulas). Two recent student Notes also contain substantive discussion of the role doulas play in promoting good maternal health outcomes. *See* Ivey E. Best, Comment, *"This Is My [D]oula—[S]he's [A]lso a [L]awyer,"* 50 CUMBERLAND L. REV. 175, 209–10 (2019) (discussing the role of doulas in observing and resisting obstetric mistreatment); Tara Wilson, Note, *Medicaid Approaches to Addressing Maternal Mortality in the District of Columbia*, 20 GEO. J. GENDER & L. 215, 228 (2018) (arguing for Medicaid coverage of doula services to address D.C.'s maternal health crisis).

disproportionately burdens Black women and other birthing people of color, who suffer higher rates of death, health complications, and mistreatment than their White counterparts.[25] It begins in Part I with a brief overview of childbirth in the United States, focusing on the historical and modern factors that help explain how it came to be that some pregnant people give birth without the support they need. Next, it summarizes in Part II the various individual and systemic benefits of continuous labor support during childbirth before turning, in Part III, to a description of the legal and professional status of doulas in the United States. Part IV tackles the question of why some hospitals or individual physicians restrict labor support and explores what doula restrictions reveal or confirm about modern childbirth and the ways that malpractice anxiety, medicalization, paternalism, and the pathologizing of birth shape birthing people's experiences.

Drawing on those insights, Part V argues that doula credentialing is a regulatory mismatch that should be abandoned by hospitals as misguided and counterproductive, and instead identifies public and private policy changes, along with related advocacy strategies, that would provide appropriate recognition and protection for doulas within the perinatal healthcare system. This Article concludes by observing that increased attention to the United States' maternal health crisis and the opportunity presented by COVID-19 to advance healthcare reforms incorporating lessons from this pandemic suggest we are approaching an inflection point regarding perinatal care provision in the United States. Advocates should seize the opportunity to resist credentialing requirements before they become the default norm, and instead pursue investment in growing the doula model as a low-cost means to improve maternal health outcomes and reduce the stark racial inequities in perinatal care. In addition,

25. *See NABJ Statement on Capitalizing Black and Other Racial Identifies*, NAT'L ASS'N OF BLACK JOURNALISTS (June 2020), https://perma.cc/X42Y-72Z4 (recommending "that whenever a color is used to appropriately describe race then it should be capitalized within the proper context, including White"); Kristen Mack & John Palfrey, *Capitalizing Black and White: Grammatical Justice and Equity*, MACARTHUR FOUND. (Aug. 26, 2020), https://perma.cc/ZWW5-MEFA ("Choosing to not capitalize White while capitalizing other racial and ethnic identifiers would implicitly affirm Whiteness as the standard and norm.").

doula-supportive policy changes would advance broader efforts to protect birthing people's autonomy, reduce unnecessary interventions, and change the culture of childbirth.

I. THE STRUGGLE(S) OVER BIRTH: HOW BIRTHING ALONE CAME TO BE

Power struggles over who can accompany a birthing person during labor and delivery are a feature of perinatal care in the United States, a fact that may seem counterintuitive to outside observers. But childbirth culture in this country is contested terrain, the product of distinct historical forces that have concentrated power in the hands of institutions and providers—and have inspired mobilization by healthcare consumers, accompanied by some midwives and doulas, to resist the medicalized, technocratic approach to childbirth that dominates mainstream perinatal care in the United States in the twenty-first century.[26] Recent efforts to preserve continuous labor support for people birthing in hospitals are only the latest struggle in a long history of conflict over who is allowed to be in the delivery room and how much control birthing people have over the circumstances surrounding their childbirth experiences.[27] This Part will provide a brief overview of modern childbirth in the United States, noting key historical developments that have shifted power away from birthing people towards healthcare providers and institutions and that have contributed to cultural norms that conceive of birth as a private, individualized experience.

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26. *See* ROBBIE E. DAVIS-FLOYD, BIRTH AS AN AMERICAN RITE OF PASSAGE 17 (2d ed. 2003)

> Since the 1960s childbirth activists have been involved in efforts to transform many of the technocratic rituals through which hospital birth is conducted into rituals that enact a more humanized view of birth and the female body. At the same time, advocates of home birth have been working to create entirely new rituals for birth—rituals that enact profoundly alternative beliefs about the nature of both birth and reality itself.

27. *See, e.g.*, Van Syckle & Caron, *supra* note 10 (describing the success of a petition in convincing the Governor of New York to "require[] all hospitals in New York . . . to allow women to have a partner in the labor and delivery room").

Before turning to the historical view, it is necessary to clarify what is meant by "birthing alone" in the context of claims that birth support should be valued and protected. This Article defines "birthing alone" broadly to mean birthing without the support one needs or desires. In some instances, the birthing person is without a single personal companion, reliant solely on busy nurses to offer physical and emotional support in addition to the clinical care they provide.[28] Someone who labors with a spouse, partner, mother, or friend at their side might also be birthing alone despite the presence of that support person if the birthing person needs particular kinds of assistance that their loved one is not equipped to provide, such as help understanding medical information to make informed decisions about interventions, navigating communication with providers, easing physical pain or discomfort without medication, or normalizing the birth experience within an alienating, institutional setting.[29] While some relatives or friends are capable of providing such support when necessary by drawing on their own personal or professional experiences, others are themselves navigating unfamiliar terrain during labor and delivery and have complex emotions witnessing their loved one experiencing the physical and emotional challenges of labor.[30] Indeed, birth doulas sometimes explain their role to family members as being available to support the support person in their support of the birthing person.[31] Thus, employing a broad conception of birthing alone enables a clearer picture of the gaps between the support a birthing person needs and the support a birthing

28. Unlike doulas, nurses are responsible for monitoring multiple laboring patients at once. *See* Kathleen R. Simpson et al., *Incorporation of the AWHONN Nurse Staffing Guidelines into Clinical Practice*, 23 NURSING FOR WOMEN'S HEALTH 217, 221 (2019). One study found that women expected nurses to spend 53% of their time providing support, but that only 6–10% of the nurses' time was dedicated to labor support activities. A. Tumblin & Penny Simkin, *Pregnant Women's Perception of Their Nurse's Role During Labor and Delivery*, 28 BIRTH 52, 53–55 (2001).

29. *See* Justine Temke, *Five Surprising Ways That Doulas Support Birthing Families!*, MIDWEST DOULAS (May 3, 2019), https://perma.cc/B6C5-TPRZ.

30. *See id.* ("As doulas, we love the families we work with, but we're not as emotionally connected as partners who have known the birthing mom a long time, which means we can be the cool head in a room.").

31. *See id.* ("[A] doula's job is to help partners as much as it is to support birthing moms.").

person receives.[32] This in turn leads to more comprehensive analysis of the individual and systemic changes that will be necessary to remove barriers to adequate support for all birthing people and lead to improved birth experiences.

A. *Historical Changes in American Childbirth*

In contrast to typical modern childbirth experiences in the United States, birth in colonial America was a social experience at home with midwives, family members, and neighbors supporting the laboring woman.[33] As labor began, a pregnant woman would "call[] her women together" and send her husband away.[34] The professionalization of physicians in the nineteenth century, however, led to assertion of medical control over childbirth, in part because physicians recognized an opportunity for economic growth by promoting themselves as desirable birth attendants instead of midwives.[35] To accomplish this goal, physicians engaged in racist anti-midwife propaganda, aimed at midwives who were immigrants or descendants of slaves, and argued in favor of "scientific" birth involving the increased use of instruments such as forceps.[36]

Though midwives continued to attend births, physician self-promotion at the turn of the twentieth century increasingly wooed pregnant women—particularly White middle- and upper-class women—to seek the assistance of physicians during birth[37] and eventually to go to the hospital to deliver their children.[38] As the twentieth century progressed, there were

32. *See id.* ("The rest of your care team, while incredibly important and skilled, will be focused on the medical side of things—your health and your baby's health. Your doula will be fully focused on your emotional and physical needs as you labor . . . .").

33. Catherine M. Scholten, *"On the Importance of the Obstetrick Art": Changing Customs of Childbirth in America, 1760 to 1825*, 34 WM. & MARY Q. 426, 427 (1977).

34. *See* JUDITH WALZER LEAVITT, BROUGHT TO BED: CHILDBEARING IN AMERICA 1750 TO 1950, 99 (1986) [hereinafter LEAVITT, BROUGHT TO BED].

35. *See* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE: THE RISE OF A SOVEREIGN PROFESSION AND THE MAKING OF A VAST INDUSTRY 49–50 (1982).

36. *See id.* at 49.

37. *See id.* at 49–50.

38. *See* LEAVITT, BROUGHT TO BED, *supra* note 34, at 40.

racial differences in who received care from physicians or midwives. The midwives who had survived efforts to eliminate their practice through legal changes in their status or through criminal prosecution[39] cared disproportionately for Black women during the first half of the twentieth century, although those numbers continued to decrease as the decades passed.[40] As childbirth became almost exclusively hospital-based by the second half of the twentieth century, laboring women were no longer supported by women in their family and community as they had been for generations.[41]

Desire for pain medication, along with the introduction of various methods to manage childbirth—applied by early twentieth century obstetricians without study or testing[42]— also led to an increasingly unrecognizable form of childbirth.[43] For example, physicians administered scopolamine to women

39. *See* Stacey A. Tovino, *American Midwifery Litigation and State Legislative Preferences for Physician-Controlled Childbirth*, 11 CARDOZO WOMEN'S L.J. 61, 70–99 (2004) (describing restrictions on midwifery in the United States through the examples of Alabama, Massachusetts, and California); Elizabeth Kukura, *Better Birth*, 93 TEMP. L. REV. 243, 281–88 (2021) [hereinafter Kukura, *Better Birth*] (discussing the historical and contemporary marginalization of midwives through legal and regulatory restrictions).

40. At the beginning of the twentieth century, physicians attended approximately half of all births. *See* LEAVITT, BROUGHT TO BED, *supra* note 34, at 161–62. In 1935, 5% of White women and 54% of Black women chose midwives as their birth attendants; by 1953, however, only 3% of White women and 20% of Black women were attended in childbirth by midwives. George W. Lowis & Peter G. McCaffery, *Sociological Factors Affecting the Medicalization of Midwifery*, *in* MIDWIFERY AND THE MEDICALIZATION OF CHILDBIRTH: COMPARATIVE PERSPECTIVES 5, 24 (Edwin Van Teijlingen et al. eds., 2004).

41. *See* Lowis & McCaffery, *supra* note 40, at 24 ("[B]y the advent of the second-wave women's movement in the 1960s, doctors were close to establishing a monopoly over maternity care in the country . . . .").

42. JUDITH PENCE ROOKS, MIDWIFERY AND CHILDBIRTH IN AMERICA 24–25 (1997) (describing "the poor overall quality of medical education" in the early twentieth century and "singl[ing] out obstetrics as making 'the very worst showing'" (citation omitted)).

43. *See* Judith Walzer Leavitt, *Birthing and Anesthesia: The Debate over Twilight Sleep*, 6 SIGNS: J. WOMEN CULTURE & SOC'Y 147, 148 (1980) [hereinafter Leavitt, *Birthing and Anesthesia*] ("Physicians used drugs and techniques of physical intervention in many cases . . . . In addition to forceps, physicians relied on opium, chloroform, chloral, cocaine, quinine, nitrous oxide, ergot, and ether to relieve pain, expedite labor, prevent injury in precipitous labors, control hemorrhage, and prevent sepsis.").

laboring in hospitals to keep them awake while inducing amnesia, leaving the women alone to labor while strapped down to a table.[44] Physicians began cutting significant episiotomies in order to facilitate instrumental deliveries of women in prone positions,[45] a practice that is now understood to heal more slowly than a natural tear and to lead to lasting injury.[46] Increased physician involvement in childbirth had coincided with new awareness about infection and the use of antiseptics, a beneficial development given the number of women who had died from puerperal fever.[47] But while professing expertise in childbirth, physicians did not attempt to learn what had been working well with woman-to-woman, community-based birth and to import those practices into physician-attended, hospital birth.[48] Instead, now located in the hospital and transformed into a

44. *See id.* at 149–50.

45. An episiotomy is a surgical incision to widen the vaginal opening, intended to create additional room for the baby's head. The procedure was introduced in the 1920s by the prominent obstetrician Dr. Joseph B. DeLee, considered a "titan" of obstetrics, without research on its efficacy or risks. ROOKS, *supra* note 42, at 25.

46. CAROL SAKALA & MAUREEN P. CORRY, EVIDENCE-BASED MATERNITY CARE: WHAT IT IS AND WHAT IT CAN ACHIEVE 49 (2008), https://perma.cc/C2VR-5KRN (PDF).

47. Rebecca Davis, *The Doctor Who Championed Hand-Washing and Briefly Saved Lives*, NPR (Jan. 12, 2015, 3:22 AM), https://perma.cc/WK3G-FZCD; Christine Hallett, *The Attempt to Understand Puerperal Fever in the Eighteenth and Early Nineteenth Centuries: The Influence of Inflammation Theory*, 49 MED. HIST. 1, 2–3 (2005). Interestingly, the shift to physician-attended, hospital-based birth did not immediately result in fewer maternal deaths. *See* Leavitt, *Birthing and Anesthesia*, *supra* note 43, at 148–49. Early twentieth-century studies showed that places with the highest percentage of midwife-attended births reported the lowest maternal mortality rates. Judy B. Litoff, *Rediscovering the Midwife*, *in* THE AMERICAN MIDWIFE DEBATE: A SOURCEBOOK ON ITS MODERN ORIGINS 5 (1986)*; see also* Judith P. Rooks, *Nurse Midwifery: The Window Is Wide Open*, 90 AM. J. NURSING 30, 31 (1990) ("At a 1925 White House conference on child health, it was reported that 'the record of trained midwives' actually 'surpasses the record of physicians in normal deliveries' . . . .").

48. *See* Judith P. Rooks, *The History of Midwifery*, OUR BODIES OURSELVES (May 30, 2012), https://perma.cc/DCD3-YEHH (last updated May 22, 2014) [hereinafter Rooks, *The History of Midwifery*] ("Where midwifery declined, the incidence of mother and infant deaths from childbearing or birth injuries generally increased.").

medical event, birth became for many women a lonely, dehumanizing, mechanistic, and sometimes cruel process.[49]

In the 1970s, the women's health movement launched a critique of mainstream medicine's treatment of women's bodies and widespread societal stigma around reproductive health.[50] In doing so, feminist activism—as articulated by predominantly White feminists—also inspired interest in "natural birth" and the reassertion of control over childbirth by women themselves.[51] In "rediscovering" midwifery practices, the movement largely ignored the "grand" or "granny" midwives, meaning the Black elder midwives who had continued to practice quietly in the South even as birth had shifted to the hospital.[52] Even so, the natural birth movement's promotion of midwifery and home birth recaptured a set of values that had largely disappeared, elevating an image of birth as something natural, beautiful, family-oriented, and community-based.[53]

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49. *See* DAVIS-FLOYD, *supra* note 26, at 57 ("Birth is thus a technocratic service that obstetrics supplies to society; the doctor delivers the baby to society."). *See generally* Robbie E. Davis-Floyd, *The Technocratic Model of Birth*, *in* FEMINIST THEORY IN THE STUDY OF FOLKLORE 297 (Susan Tower Hollis et al. eds., 1993).

50. *See generally* BOSTON WOMEN'S HEALTH BOOK COLLECTIVE, OUR BODIES, OURSELVES (1970); Francine H. Nichols, *History of the Women's Health Movement in the 20th Century*, 29 J. OBSTETRIC, GYNECOLOGIC & NEONATAL NURSING 56 (2000).

51. *See* Rooks, *The History of Midwifery*, *supra* note 48 ("A small number of mostly well-educated, middle-class, white women started choosing to have home births with an informally-trained 'lay' midwives, who are now more often referred to as direct-entry midwives."). *But see* Jessica Grose, *Welcome to NYT Parenting. Here's Why We Won't Say 'Natural Birth'*, N.Y. TIMES (May 7, 2019), https://perma.cc/A8V2-U6UR (noting the imprecision of the term "natural birth" and calling for more inclusive language to account for the variety of ways babies are born).

52. *See, e.g.*, Nina Renata Aron*, Meet the Unheralded Women Who Saved Mothers' Lives and Delivered Babies Before Modern Medicine*, TIMELINE (Jan. 12, 2018), https://perma.cc/23YR-MX6F ("This history [of women in medicine] has enjoyed a resurgence in recent years, as interest in home birth, natural birthing methods, and midwifery had skyrocketed (albeit largely among upper-middle-class white women) . . . .").

53. *See* Katherine Beckett & Bruce Hoffman, *Challenging Medicine: Law, Resistance, and the Cultural Politics of Childbirth*, 39 LAW & SOC'Y REV. 125, 131–32, 136–37 (2005) ("[A]lternative birthing communities . . . drew their inspiration from the women's health, countercultural, and civil rights movements, as well as from practicing midwives."); WENDY KLINE, COMING HOME: HOW MIDWIVES CHANGED BIRTH 62 (2018) (discussing creation of early

Efforts to humanize childbirth practices were not limited to promoting birth with midwives at home or in birth centers. As reliance on heavy sedatives waned and women were awake for their labors, advocates also targeted hospital restrictions on fathers being present for their children's birth.[54] Historically, husbands had been excluded from hospital labor and delivery wards, relegated to waiting rooms nicknamed "stork clubs."[55] Along with the natural childbirth movement, childbirth educators, and feminist activists, fathers challenged their exclusion, but change was gradual.[56] By the 1950s and 1960s, hospitals began allowing husbands to join their wives in the labor room.[57] Finally, in the 1970s and 1980s, male partners were regularly allowed to stay in the delivery room for the birth itself.[58]

Despite important changes spurred by the natural birth movement, childbirth has continued to be a highly medicalized endeavor in the United States.[59] Consumer demand for midwifery care and alternatives to the technocratic,

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freestanding birth centers for home birth in the 1970s). *See generally* INA MAY GASKIN, SPIRITUAL MIDWIFERY (4th ed. 2002) (discussing prominent self-taught White midwife Ina May Gaskin's involvement in establishing the Farm, a Tennessee commune where Gaskin reported positive birth outcomes and educated others in supporting physiologic birth at home).

54. *See* Judith Walzer Leavitt, *How Did Men End Up in the Delivery Room?*, HIST. NEWS NETWORK (Sept. 7, 2009), https://perma.cc/8KGQ-PYT5 [hereinafter Leavitt, *Men in the Delivery Room*] ("The men contested the separate hospital spaces and the exclusionary routines of medical authority to find a place of themselves and, in so doing, created unprecedented new masculine domestic roles while enhancing the birth experience for mothers.").

55. Deena Prichep, *This Father's Day, Remembering a Time When Dads Weren't Welcome in Delivery Rooms*, NPR (June 18, 2017), https://perma.cc/9LVN-EVD3.

56. Leavitt, *Men in the Delivery Room*, *supra* note 54.

57. *Id.* (quoting a laboring woman who said, "It just made me feel peaceful and confident, somehow, just his sitting there").

58. *Id. See generally* JUDITH LEAVITT, MAKE ROOM FOR DADDY: THE JOURNEY FROM WAITING ROOM TO BIRTHING ROOM (2009).

59. *See* DAVIS-FLOYD, *supra* note 26, at xiv ("Between cesarean sections, forceps deliveries, vacuum extractions, and episiotomies, about 60 percent of American births are 'operative deliveries.'"); Every Mother Counts, *Over-medicalization of Maternal Health in America*, MEDIUM (Sept. 11, 2014), http://perma.cc/7GBK-4XQG ("Only 15% of pregnancies will include some level of medical complication, yet our traditional obstetric model of care commonly treats most pregnancies as if they're at high risk for complications.").

intervention-heavy approach to childbirth available in most hospitals has led to a steadily increasing number of births occurring in community settings—at home or in freestanding birth centers—attended by midwives.[60] However, these births still account for less than 2% of births in the United States each year.[61] Advocates continue to promote natural childbirth education, encourage the use of doulas, and campaign against restrictive visitor policies—all of which represent efforts to change the hospital delivery room environment from one of aloneness and fear to one where birthing people are supported.

B. *Characteristics of Modern Perinatal Care in the United States*

The specialty of obstetrics-gynecology in the United States has a fraught and contested history, which includes the assertion of control over midwife-attended childbirth by entrepreneurial physicians,[62] the racist exclusion of midwives from hospital care,[63] clinical norms that grew out of the untested theories of obstetricians like Dr. Joseph B. DeLee,[64] and the legacy of experimentation on Black female slaves—often repeatedly and without anesthesia—that contributed to the development of contemporary gynecological surgical practices.[65]

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60. After declining gradually from 1990 to 2004, the percentage of out-of-hospital births increased from 0.87% of births in 2004 to 1.61% of births in 2017—an 85 percent increase in less than fifteen years. Marian F. MacDorman & Eugene Declercq, *Trends and State Variations in Out-of-Hospital Births in the United States, 2004-2017*, 46 BIRTH 279, 280 (2019); *see id.* at 1 (explaining that the National Center for Health Statistics defines "out-of-hospital" to include home, birth center, clinic or doctor's office, or other non-hospital location).

61. *Id.*

62. *See supra* notes 35–38 and accompanying text.

63. *See* Kukura, *Better Birth*, *supra* note 39, at 257.

64. *See* ROOKS, *supra* note 42, at 25 ("To avoid 'laceration, prolapse and all the evils' that are 'natural to labor,' DeLee proposed a program of regular medical intervention . . . ."); *see also* Judith Walzer Leavitt, *Joseph DeLee and the Practice of Preventive Obstetrics*, 78 AM. J. PUB. HEALTH 1353, 1353 (1988) ("[DeLee's] interventions, it is argued, put birthing women at greater risk from associated complications than they might have been subjected to if labor had progressed without surgical interference.").

65. *See* HARRIET A. WASHINGTON, MEDICAL APARTHEID: THE DARK HISTORY OF MEDICAL EXPERIMENTATION ON BLACK AMERICANS FROM COLONIAL TIMES TO THE PRESENT 64–68 (2006); *see also id.* at 103 (explaining that slaves "who had

Indeed, perinatal care in the United States today is deeply flawed—costly, overly medicalized, and producing subpar outcomes, both in terms of maternal and infant health, and in terms of patient experience.[66] This Subpart will summarize several critiques of modern perinatal care to contextualize the experiences of birthing people seeking care in hospitals and to provide a foundation for understanding the role of a doula in modern childbirth.

The medicalized nature of childbirth in the United States is reflected in the high rates of intervention that birthing people experience when delivering in a hospital.[67] More than three in ten births are by cesarean surgery,[68] which is notably higher than the 10 percent to 15 percent of births that the World Health Organization considers to be medically necessary in a high-resource country like the United States.[69] Many other

become too old or too sick to work" would be used as "clinical material" for medical teaching, training, and research in American hospitals). Because enslaved people had no legal rights, they were unable to challenge this incarceration and forced medical treatment. *Id.* at 104. Additionally, they were not given anesthesia due to the pervasive belief that "blacks did not feel pain in the same way as whites." *Id.* at 65.

66. *See infra* notes 72–81 and accompanying text.

67. *See, e.g.*, CAL. HEALTH CARE FOUND., THE OVERMEDICALIZATION OF CHILDBIRTH 1 (2018), https://perma.cc/D9UD-FKTS (PDF) ("According to the *Listening to Mothers in California* survey, 74% of California mothers agreed that childbirth should not be interfered with unless medically necessary, but only 5% gave birth without major medical intervention.").

68. Michelle J.K. Osterman et al., *Births: Final Data for 2020*, NAT'L VITAL STATS. REPS., Feb. 7, 2022, at 6 (reporting that the cesarean rate increased to 31.8% in 2020, up from 31.7% in 2019 but down from the peak at 32.9% in 2009).

69. *See* World Health Org., *Appropriate Technology for Birth*, 326 LANCET 436, 437 (1985) ("Countries with some of the lowest perinatal mortality rates in the world have cesarean section rates of less than 10%. There is no justification for any region to have a rate higher than 10–15%."); *Caesarean Sections Should Only Be Performed When Medically Necessary*, WORLD HEALTH ORG. (Apr. 10, 2015), https://perma.cc/3S4C-UTSD ("Since 1985, the international healthcare community has considered the 'ideal rate' for caesarean sections to be between 5% and 10%."); Fernando Althabe & José M. Belizán, *Cesarean Section: The Paradox*, 368 LANCET 1472, 1472–73 (2006) ("For the health of both the mother and the neonate, . . . a frequency of [caesarean sections] between 5% and 10% seems to achieve the best outcomes, whereas a rate of less than 1%, or of higher than 15% seems to result in more harm than good."). More recent research suggests that a 19 percent cesarean rate is the benchmark for the United States. Martha Bebinger, *Study Suggests*

interventions to induce, accelerate, monitor, or manage labor and delivery are common. In a recent study of women's childbearing experiences, 62% reported being attached to an IV during labor, 47% had bladder catheters, 41% had a care provider try to induce labor, 31% received synthetic oxytocin to expedite labor, and 20% reported that their membranes had been ruptured to release amniotic fluid after labor began (in the hopes of speeding up the delivery).[70] Research shows that many of these common interventions are not supported by the best available evidence, meaning that birthing people regularly experience the unnecessary administration of medication, unnecessary monitoring that disrupts labor, and unnecessary surgery.[71] Perhaps not surprisingly, more intervention is costly, and indeed, the cost of childbirth has increased significantly over the last two decades.[72] Significantly, over 40% of births are paid for by Medicaid.[73]

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19 Percent Could Be Benchmark C-Section Rate, WBUR (Dec. 1, 2015), http://perma.cc/V3ZN-MZC2.

70. EUGENE R. DECLERCQ ET AL., LISTENING TO MOTHERS III: PREGNANCY AND BIRTH, at XI-XIII, 18–19 (2013), https://perma.cc/F296-AL6L (PDF).

71. *See* SAKALA & CORRY, *supra* note 46, at 21

> The principle of effective care with least harm has two corollaries. First, practices with established or plausible adverse effects should be avoided when best available research identifies no clear anticipated benefit to justify their use. . . . An evidence-based framework also questions the wisdom of using interventions with a marginal expected benefit that is overshadowed by greater risk of established harm.

see also Elizabeth Kukura, *Contested Care: The Limitations of Evidence-Based Maternity Care Reform*, 31 BERKELEY J. GENDER L. & JUST. 241, 270–77 (2016) [hereinafter Kukura, *Contested Care*] (discussing the gaps between research and practice regarding induction of labor, pain relief, labor management, and delivery). Research also shows that interventions that interfere with physiologic labor often lead to more intervention to manage and treat side effects of the original interventions, often bearing additional risk to the birthing person and the baby—a phenomenon referred to as the "cascade of secondary interventions." *Id.* at 263.

72. *See* Elisabeth Rosenthal, *American Way of Birth, Costliest in the World*, N.Y. TIMES (June 30, 2013), https://perma.cc/86RV-QF4K ("[C]harges for delivery [in the United States] have tripled since 1996 . . . . Childbirth in the United States is uniquely expensive, and maternity and newborn care constitute the single biggest category of hospital payouts for most commercial insurers and state Medicaid programs.").

73. *See* Osterman et al., *supra* note 68, at 6.

Data suggest that high rates of intervention have not produced better outcomes. The United States has a shockingly high maternal mortality rate,[74] as well as an infant mortality rate that ranks it lower than many of its peer nations.[75] Approximately seven hundred to nine hundred people die from pregnancy-related causes each year, and another sixty-five thousand experience life-threatening complications.[76] Researchers estimate that roughly 60 percent of those deaths are preventable and that many of them occur when postpartum complications are left unaddressed.[77] The risk is not borne equally across the population. In particular, Black women are approximately three to four times more likely than White women to die from pregnancy-related causes,[78] and Native women are estimated to die at a rate that is 4.5 times greater than the maternal mortality rate for non-Hispanic White women.[79]

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74. *See* Kukura, *Better Birth*, *supra* note 39, at 245–46 (compiling sources on maternal mortality in the United States and providing comparisons to the rates of other developed countries).

75. *See Infant Mortality*, CDC, https://perma.cc/7M6L-AC8G (last updated June 22, 2022) (reporting an infant mortality rate of 5.4 deaths per one thousand live births in 2020 and even higher rates for children born to parents who are racial or ethnic minorities); *see also* David Johnson, *American Babies Are Less Likely to Survive Their First Year Than Babies in Other Rich Countries*, TIME (Jan. 9, 2018, 11:00 AM), https://perma.cc/24Q6-K5G9.

76. Nina Martin & Renee Montagne, *The Last Person You'd Expect to Die in Childbirth*, PROPUBLICA (May 12, 2017), https://perma.cc/YCL2-WBXU (last updated July 28, 2017).

77. *See Pregnancy-Related Deaths*, CDC, https://perma.cc/SHB6-DNYM (lasted updated May 7, 2019) ("Every pregnancy-related death is tragic, especially because about 60% are preventable. . . . A pregnancy-related death can happen during pregnancy, at delivery, or even up to a year afterward (postpartum). For 2011–2015 . . . about 1/3 (33%) happened 1 week to 1 year postpartum."); *see also* Julie Zahartos et al., *Building U.S. Capacity to Review and Prevent Maternal Deaths*, 27 J. WOMENS HEALTH 1, 1 (2018).

78. *See Pregnancy Mortality Surveillance System*, CDC, https://perma.cc/2PB6-RWWQ (last updated June 22, 2022) (reporting a death rate of 41.4 per one hundred thousand live births for non-Hispanic Black women and 13.7 deaths per one hundred thousand live births for non-Hispanic White women between 2016 and 2018); Myra J. Tucker et al., *The Black-White Disparity in Pregnancy-Related Mortality from 5 Conditions: Differences in Prevalence and Case-Fatality Rates*, 97 AM. J. PUB. HEALTH 247, 247 (2007).

79. *See* Mary Annette Pember, *Amid Staggering Maternal and Infant Mortality Rates, Native Communities Revive Traditional Concepts of Support*, REWIRE NEWS GRP. (July 9, 2018, 11:05 AM), https://perma.cc/5ACM-R7DN.

Not only do birthing people die and suffer life-threatening complications at tragically high rates, but a significant proportion of them emerge from the childbirth experience with emotional and psychological scars. A growing number of people are reporting mistreatment at the hands of their healthcare providers during childbirth, which is likely a reflection of increased willingness to report and not an actual increase in incidence of mistreatment.[80] Such mistreatment—which is sometimes referred to as obstetric violence—may include abuse, such as forced surgeries, physical restraint, or unconsented administration of medication; coercion, such as threats to secure court orders or report to child welfare authorities for a patient's refusal to consent to induction or cesarean, or threats to withhold pain medication in the absence of patient compliance with a healthcare provider's recommendation; or disrespect, which includes bullying, insults, and disclosure of sensitive medical information.[81] A recent study found that 17% of women reported one or more types of mistreatment, including loss of

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The cofounder of a Native American center for Minnesota-based pregnant and birthing people, Millicent Simenson, expressed dismay at this reality, stating, "We stopped keeping statistics on the number of Native moms and babies that are lost in our region; it was just too upsetting." *Id.*

80. *See* Saraswathi Vedam et al., *The Giving Voice to Mothers Study: Inequity and Mistreatment During Pregnancy and Childbirth in the United States*, 16 REPROD. HEALTH, June 11, 2019, at 15 (noting that "women with very positive or very negative experiences are often more motivated to participate in studies that invite them to share their stories").

81. *See* Farah Diaz-Tello, *Invisible Wounds: Obstetric Violence in the United States*, 24 REPROD. HEALTH MATTERS 56, 57 (2016) ("[O]bstetric violence is an infringement of women's human rights to non-discrimination, liberty and security of the person, reproductive health and autonomy, and freedom from cruel, inhuman, and degrading treatment."); Elizabeth Kukura, *Obstetric Violence*, 106 GEO. L.J. 721, 728–754 (2018) [hereinafter Kukura, *Obstetric Violence*]; *see also* Olivia Miltner, *'It Felt Like I Had Been Violated': How Obstetric Violence Can Traumatize Patients*, REWIRE NEWS GRP. (Jan. 23, 2019, 7:30 AM), https://perma.cc/PR4X-GBDC ("One study found that the most common factor behind traumatic births was a lack of loss or control. And traumatic births—which up to a third of women experience, according to one study—can lead to postpartum depression, anxiety, and post-traumatic stress disorder."); Sarah Yahr Tucker, *There Is a Hidden Epidemic of Doctors Abusing Women in Labor, Doulas Say*, VICE (May 8, 2018, 12:08 PM), https://perma.cc/UQA9-KYTD ("Rather than offering comfort measures or encouragement at births, [the doula] felt she was really there to keep her clients safe, to protect their physical autonomy, to shield them from being victimized, and failing that, to stand as a witness to their abuse.").

autonomy; being shouted at, scolded, or threatened; and being ignored, refused, or receiving no response to requests for help.[82] "Women of colour, women who gave birth in hospitals, and those who face social, economic, or health challenges reported higher rates of mistreatment."[83] Relatedly, a growing number of women are reporting birth trauma, using the language of "trauma" and "rape" to describe their treatment during labor and delivery.[84] One study found that up to 9% of new mothers satisfy the clinical criteria for post-traumatic stress disorder.[85]

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82. Vedam et al., *supra* note 80, at 7–8.

83. *Id*. at 1. It is perhaps not surprising that women of color report higher rates of mistreatment, given research findings on racial bias in medicine more generally. *See, e.g.*, Joseph V. Sakran et al., *Racism in Health Care Isn't Always Obvious*, SCI. AM. (July 9, 2020), https://perma.cc/DZ4E-9VU5 ("[A] study . . . evaluated physicians who self-reported no explicit preference for white versus Black patients. . . . [A]fter completion of an implicit bias test, those same health care workers demonstrated a significant preference favoring white Americans, while their perception of Black Americans was negative relative to cooperation with medical procedures."); *see also* Kelly M. Hoffman et al., *Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs About Biological Differences Between Blacks and Whites*, 113 PROC. NAT'L ACAD. SCIS. 4296, 4300 (2016) ("[B]eliefs about biological differences between blacks and whites—beliefs dating back to slavery—are associated with the perception that black people feel less pain than do white people and with inadequate treatment recommendation for black patients' pain."); Elizabeth N. Chapman et al., *Physicians and Implicit Bias: How Doctors May Unwittingly Perpetuate Health Care Disparities*, 28 J. GEN. INTERNAL MED. 1504, 1508 (2013) ("Implicit bias is present in physicians and correlates with unequal treatment of patients."); John F. Dovidio & Susan T. Fiske, *Under the Radar: How Unexamined Biases in Decision-Making Processes in Clinical Interactions Contribute to Health Care Disparities*, 102 AM. J. PUB. HEALTH 945, 949 (2012) ("Although racial and ethnic disparities in health can be caused by several factors other than bias in health care—and are largely attributed to those factors—discrimination in health care plays a significant role.").

84. *See, e.g.*, Brief of Human Rights in Childbirth et al. as Amici Curiae Supporting Plaintiff, Rinat Dray v. Staten Island Univ. Hosp., 160 A.D.3d 614 (N.Y. App. Div. 2014) (No. 500510/2014), at 33–35; *see also* Penny Simkin, *Birth Trauma: Definition and Statistics*, PREVENTION & TREATMENT OF TRAUMATIC CHILDBIRTH, https://perma.cc/9FMZ-TCWD ("Between 25 and 34 per cent of women report that their births were traumatic.").

85. Cheryl Tatano Beck et al., *Posttraumatic Stress Disorder in New Mothers: Results from a Two-Stage U.S. National Survey*, 38 BIRTH 216, 217 (2011); *see* Cheryl Tatano Beck, *Post-Traumatic Stress Disorder Due to Childbirth: The Aftermath*, 53 NURSING RES. 216, 216 (2004) ("The reported prevalence of diagnosed PTSD after childbirth ranges from 1.5% to 6%." (citations omitted)). Other research suggests that birth trauma is associated

In particular, when a birthing person questions a provider's treatment recommendation or declines to consent to an intervention such as induction or cesarean, this can generate friction between the patient and provider, leading to a breakdown in communication and sometimes increased efforts on the part of the provider to get the patient to agree to an intervention.[86] Significantly, 30% of Black and Hispanic women and 21% of White women—all giving birth for the first time and delivering in hospitals—reported that they were "treated poorly because of a difference of opinion with [their] caregivers about the right care for [herself or her] baby."[87] Given the power imbalance between obstetricians and birthing people,[88] the association between lack of decision-making autonomy and postpartum psychological trauma,[89] and the extent to which some obstetrical recommendations lack evidence to support them,[90] the use of coercion to secure patient acquiescence to treatment is troubling. It violates important legal and ethical principles that apply in health care, such as informed consent, bodily autonomy, and the right to refuse medical treatment.[91] This phenomenon also highlights a reason why some birthing people find doulas so valuable: doulas can help the birthing person identify and resist coercion to give consent, seek clarification about the risks and benefits of any proposed

with experiencing coercion to consent to treatment apart from whether complications arose during the delivery. *See* Kukura, *Obstetric Violence*, *supra* note 81 at 756.

86. *See* Kukura, *Obstetric Violence*, *supra* note 81 at 777 ("Rather than having the opportunity to weigh the risks and benefits of different approaches, and make the decision they consider best, women find themselves bullied, coerced, or forced to accept unwanted medical intervention."); Michelle Oberman, *Mothers and Doctors' Orders: Unmasking the Doctor's Fiduciary Role in Maternal-Fetal Conflicts*, 94 NW. U. L. REV. 451, 454 (2000) ("When a pregnant woman resists medical advice, the doctor often invests the fetus with interests and rights that directly coincide with his own personal treatment preferences. The pregnant woman's interests are then rendered in direct opposition to those attributed by the doctor to her fetus.").

87. Vedam et al., *supra* note 80, at 3 (alteration in original).

88. *See* Oberman, *supra* note 86, at 496.

89. *See* Kukura, *Obstetric Violence*, *supra* note 81, at 756–57.

90. *See* Kukura, *Contested Care*, *supra* note 71, at 270–77.

91. *See* Kukura, *Obstetric Violence*, *supra* note 81, at 779–95 (analyzing these rights in the context of mistreatment during childbirth).

treatment, and advocate for themselves with insistent or hostile physicians.[92]

II. WHY IT MATTERS: THE BENEFITS OF SUPPORT DURING CHILDBIRTH

Decades of research has shown that doula care improves perinatal health outcomes on measures of both physical and mental health, while also offering potential cost savings in perinatal care. As the American College of Obstetricians and Gynecologists has acknowledged, "One of the most effective tools to improve labor and delivery is the continuous presence of support personnel, such as a doula."[93]

A. *Health Benefits*

Research on the benefits of continuous labor support dates to the 1980s, beginning with a randomized trial in Guatemala, which was replicated in a 1991 study of 412 women in U.S. hospitals that showed significant reduction in the rates of cesarean and forceps delivery, decreased oxytocin augmentation, and shortened labor for doula-assisted women giving birth for the first time.[94] Additional high-quality research in the 1990s showed the positive impact of continuous labor support. These studies further confirmed that doula support is associated with fewer instrumental deliveries, less need for oxytocin augmentation of labor, and shorter duration of labor.[95]

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92. Mary-Powel Thomas et al., *Doula Services Within a Healthy Start Program: Increasing Access for an Underserved Population*, 21 MATERNAL & CHILD HEALTH J. S59, S61 (2017).

93. Am. Coll. of Obstetricians & Gynecologists & Soc'y for Maternal Fetal Med., *ACOG/SMFM Obstetric Care Consensus: Safe Prevention of the Primary Cesarean Delivery*, 210 AM. J. OF OBSTETRICS & GYNECOLOGY 179, 189 (2014) [hereinafter *ACOG/SMFM Obstetric Consensus*]; *see also* Alice Dreger, *The Most Scientific Birth Is Often the Least Technological Birth*, THE ATL. (Mar. 20, 2012), https://perma.cc/VC42-V7K5 ("Studies show that doulas are astonishingly effective at lowering risk, so good that one obstetrician has quipped that if doulas were a drug, it would be illegal not to give one to every pregnant woman.").

94. J. Kennell, et al., *Continuous Emotional Support During Labor in a US Hospital: A Randomized Controlled Trial*, 265 JAMA 2197, 2198–200 (1991).

95. *See* Ellen D. Hodnett et al., *Continuous Support for Women During Childbirth*, 2013 COCHRANE DATABASE OF SYSTEMIC REVS., July 13, 2013, at 1,

Continuous labor support is also associated with higher Apgar scores and higher satisfaction with the labor process by birthing people.[96] Significantly, a 2017 review that analyzed data from twenty-six individual studies involving more than fifteen thousand women found a 39% reduction in the likelihood of cesarean delivery and a 15% increase in likelihood of spontaneous vaginal birth with continuous labor support.[97] Such labor support reduces the need for interventions, resulting in a reduction in the use of pain medications.[98] This finding is significant given the potential side effects of common pain medications like epidurals.[99] The 2017 review also reported that doula support results in shorter labors by an average of forty-one minutes.[100]

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2 ("Women who received continuous labour support were more likely to give birth . . . with neither cesarean nor vacuum nor forceps. In addition, women were less likely to use pain medications, were more likely to be satisfied, and had slightly shorter labours."); Della A. Campbell et al., *A Randomized Control Trial of Continuous Support in Labor by a Lay Doula*, 35 J. OBSTETRIC, GYNECOLOGIC, & NEONATAL NURSING 456, 456 (2006) ("Meta-analysis of randomized clinical trials have demonstrated that women who have continuous support during labor have a reduction in the Cesarean delivery rate, length of labor, the need for analgesia, operative vaginal delivery, and 5-minute Apgar scores less than 7." (citations omitted)); Marshall Klaus & Phyllis Klaus, *Academy of Breastfeeding Medicine Founder's Lecture 2009: Maternity Care Re-Evaluated*, 5 BREASTFEEDING MED. 3, 7 (2010) ("The studies demonstrated that labor was shortened by 25% with a doula who was with the mother continuously. The cesarean rate was reduced by 45%, pain medication to the mother was reduced by 30%, use of forceps by 40%, and epidural use by 30–60%."); Karla Papagni & Ellen Buckner, *Doula Support and Attitudes of Intrapartum Nurses: A Qualitative Study From the Patient's Perspective*, 15 J. PERINATAL EDUC. 11, 14 (2006) ("[D]ozens of studies herald the benefits of continuous labor support and several more studies indicate that a doula may be the best provider of that continuous support . . . ."); Donna J. Sauls, *Effects of Labor Support on Mothers, Babies, and Birth Outcomes*, 31 J. OBSTETRIC, GYNECOLOGIC, & NEONATAL NURSING, 733, 735–36 (2002).

96. Sauls, *supra* note 95, at 737, 738.

97. Megan A. Bohren et al., *Continuous Support for Women During Childbirth*, 2017 COCHRANE DATABASE SYSTEMATIC REVS., July 6, 2017, at 1, 4–5; Nat'l Partnership for Women & Families, *Continuous Support for Women During Childbirth: 2017 Cochrane Review Update Key Takeaways*, 27 J. PERINATAL EDUC. 193, 195 (2018).

98. Bohren et al., *supra* note 97, at 2; Nat'l Partnership for Women & Families, *supra* note 97, at 194.

99. *See* Healthline Editorial Team, *Risks of Epidurals During Delivery*, HEALTHLINE (Feb. 8, 2018), https://perma.cc/YS39-667B.

100. *See* Bohren et al., *supra* note 97, at 5.

Research shows that birthing people of color and poor birthing people benefit from continuous labor support provided by doulas,[101] which is important given that they experience adverse perinatal health outcomes at disproportionate rates. In Minnesota, one of only four states that currently provides Medicaid reimbursement for doula services, Medicaid beneficiaries with doula support were 22% less likely to give birth prematurely and 56% less likely to have a cesarean delivery.[102] A 2013 study of socially disadvantaged women in North Carolina found that doula-assisted women were four times less likely to have a low birth weight baby, two times less likely to experience maternal or infant health complications due to birth, and significantly more likely to breastfeed.[103] Study authors observed that there were significant differences in outcomes between the doula-assisted and non-doula-assisted women, despite the fact that all participants in the program received childbirth education classes and other peer-group support, including prenatal health and fitness classes, health literacy, and case management.[104] This led the researchers to conclude that "women who embraced the premise that a doula may help empower them to influence their birthing experience" may also have believed that "they could improve their prenatal health and the likelihood of a healthy birth outcome through their active participation and engagement in the healthy prenatal activities offered by this program"—in effect suggesting that access to doula support may be broadly empowering for socially disadvantaged pregnant people beyond labor and delivery themselves.[105] In addition, research suggests that adolescents and women with intellectual disabilities also benefit from doula support.[106]

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101. *See* Kenneth J. Gruber et al., *Impact of Doulas on Healthy Birth Outcomes*, 22 J. PERINATAL EDUC. 49, 49–51 (2013).

102. Mattie Quinn, *To Reduce Fatal Pregnancies, Some States Look to Doulas*, GOVERNING (Dec. 18, 2018), https://perma.cc/CYM5-KUB6.

103. Gruber, *supra* note 101, at 54–55.

104. *See id*. at 55.

105. *Id.*

106. *See* Lynae Carlson, The Effects of Doula Care on Birth Outcomes and Patient Satisfaction in the United States 14–16 (Dec. 2021) (B.S. honors thesis, Eleanor Mann School of Nursing) (on file with ScholarWorks@UARK, University of Arkansas, Fayetteville).

The benefits of doula care are visible not only in improved physical health outcomes but also in the positive impact on mental and emotional health associated with doula support.[107] Put simply, continuous labor support improves childbirth experiences for pregnant and birthing people.[108] The 2017 systematic review capturing the experiences of over fifteen thousand doula-assisted women reflected a 31% reduction in birthing people reporting that childbirth was a negative experience.[109] Satisfaction with the birth experience has important health consequences beyond the subjective emotions and feelings of the individual birthing person, as it is linked with successful maternal-infant bonding, successful breastfeeding, and reduced incidence of postpartum mental health issues.[110] In particular, research suggests that positive birth experiences are associated with better emotional and psychological health in the form of reduced postpartum anxiety, reduced postpartum depression, and fewer symptoms of post-traumatic stress disorder.[111]

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107. Therapeutic jurisprudence supports the idea that the benefits to mental and emotional health are as important as the benefits to physical health when considering forms of regulation that will increase or reduce access to doula support. *See* Kathy L. Cerminara, *Therapeutic Jurisprudence's Future in Health Law: Bringing the Patient Back into the Picture*, 63 INT'L J.L. PSYCHIATRY 56, 58 (2019) ("By incorporating research from the social sciences about the impact on patients of legal rules and process, [therapeutic jurisprudence] can give meaning to the patient in a health care system that often seems to have forgotten that its central focus should be good outcomes for those patients.").

108. *See supra* notes 94–106 and accompanying text.

109. *See* Bohren, *supra* note 97, at 2; Nat'l Partnership for Women & Families, *supra* note 97, at 194; Rebecca Dekker et al., *Evidence On: Doulas*, EVIDENCE BASED BIRTH (Mar. 27, 2013), https://perma.cc/4W4R-3CRE (last updated May 4, 2019).

110. *See* Kukura, *Obstetric Violence*, *supra* note 81, at 756–57 (discussing research on the association between the emotional impact of the birth experience and various health measures for both birthing person and baby); *cf.* Vedam et al., *supra* note 80, at 2 (linking serious adverse consequences to traumatic birth experience caused by mistreatment by health providers or health systems).

111. *See* Teresa Janevic et al., *Pandemic Birthing: Childbirth Satisfaction, Perceived Health Care Bias, and Postpartum Health During the COVID-19 Pandemic*, 25 MATERNAL & CHILD HEALTH J. 860, 862–64 (2021); Heidi Preis et al., *Between Expectancy and Experience: Testing a Model of Childbirth Satisfaction*, 43 PSYCH. WOMEN Q. 105, 105–07 (2018).

The link between doula support and positive mental and emotional health outcomes makes sense in light of research showing that satisfaction with the birth experience often reflects the extent to which the birthing person had a meaningful opportunity to make decisions about treatment during labor and delivery rather than feeling like decisions were imposed upon them without their input—in effect, the extent to which healthcare providers obtained meaningful informed consent for treatment during labor and delivery.[112] Because doulas "can facilitate positive communication between the birthing person and their care providers by helping people articulate their questions, preferences and values," they have the potential to increase patient satisfaction with the birth experience and avoid the detrimental health consequences associated with negative experiences.[113] Furthermore, in situations where disagreement or conflict arises between providers and patients, doulas can help birthing people advocate for themselves in the face of coercion and disrespect, preserving agency and avoiding the trauma associated with coerced treatment. Given that obstetric mistreatment and violence are disproportionately experienced by people of color, continuous labor support can provide forms of buffer and accountability that reduce the risks associated with experiencing mistreatment during childbirth.[114]

Other studies have confirmed the benefits of doula support on infant health outcomes and on maternal-infant adjustment in the early postpartum period. For example, continuous labor support reduces prematurity and illness in newborns, and the

112. *See* Vedam et al., *supra* note 80, at 6 (linking negative health outcomes to a birthing person's hesitation to ask questions and medical staff's failure to explain treatment or provide options); Cristen Pascucci, *Caught on Video: Improving Birth Breaks Silence on Abuse of Women in Maternity Care*, IMPROVING BIRTH (Aug. 28, 2014), https://perma.cc/Y3K6-PGK8 ("[T]he strongest predictor of developing PTSD after labor was not a history of trauma, but rather *the level of coercion the women experienced during their labor and delivery*." (emphasis in original)); Preis, *supra* note 111, at 112; Katie Cook & Colleen Loomis, *The Impact of Choice and Control on Women's Childbirth Experiences*, 21 J. PERINATAL EDUC. 158, 159, 166 (2012) ("[W]omen's positive and negative recollections of their birth experience were more related to experiences of choice and control than they were to . . . the particular interventions that were chosen or necessary during a woman's birth experience.").

113. BEY ET AL., *supra* note 8, at 5.

114. *See id.*

reduced incidence of postpartum depression discussed above aids in maternal-infant bonding.[115] Doula support also increases initiation and duration of breastfeeding, which Black women and other birthing people of color generally report lower rates of than White women.[116] For example, a 2012 expert panel convened by the U.S. Health Resources and Services Administration to evaluate four years of funding of community doula programs found that approximately 87% of community-based doula clients were breastfeeding at six weeks compared with 61% of the comparison group; at three months, 72% were still breastfeeding, compared with 48% of the comparison group.[117]

The benefits of receiving continuous labor support from someone serving in a non-medical capacity are clear from the improved health outcomes reported by birthing people overall. Research also shows that doula support is an effective intervention to reduce racial, ethnic, and socioeconomic perinatal health disparities because it improves outcomes on a variety of measures with an increased risk of adverse outcomes

115. *See* HEALTHCONNECT ONE, THE PERINATAL REVOLUTION 32 (2014), https://perma.cc/SF3L-W4UV (PDF) [hereinafter THE PERINATAL REVOLUTION] (finding that doula support leads to high breastfeeding rates, which result in lower rates of illness and chronic disease for both mother and baby); Katy B. Kozhimannil et al., *Modeling the Cost-Effectiveness of Doula Care Associated With Reductions in Preterm Birth and Cesarean Delivery*, 43 BIRTH 20, 23 (2016) (observing a 22% lower chance of preterm birth with doula support); Coralie Trotter et al., *The Effect of Social Support During Labour on Postpartum Depression*, 22 S. AFR. J. PSYCHOL. 134, 137 (1992) (observing significantly lower rates of postpartum depression with doula support).

116. *See* THE PERINATAL REVOLUTION, *supra* note 115, at 5 ("Women supported by a high-quality Community-Based Doula Program breastfed their babies at dramatically higher rates . . . ."); Thomas et al., *supra* note 92, at 60.

117. THE PERINATAL REVOLUTION, *supra* note 115, at 28–29; *see also id.* at 38 ("HRSA should continue to promote and expand the Community-Based Doula Program with federal funding, based on the uniqueness of the model, the workforce development implications, and the data analysis which identifies significant and important outcomes."). See Section III.B, *infra*, for a description of the community doula model and its focus on serving socially disadvantaged pregnant people at low or no cost to increase the ability of poor birthing people and birthing people of color to experience the health benefits of doula support.

for birthing people who are poor or who identify as members of racialized minority groups.[118]

B. *Cost Benefits*

Doula support is a relatively inexpensive way to improve perinatal health outcomes, and it also provides additional cost benefits by reducing both immediate and long-term medical expenses. As discussed in Part II.A, continuous labor support reduces the need for medical intervention during labor and delivery, thus helping birthing people avoid unnecessary and expensive medical procedures as well as any associated complications. Doula support also helps reduce the need for expensive NICU admissions to monitor and treat infant health complications resulting from difficult deliveries.[119]

The relationship between continuous labor support and both higher rates of breastfeeding initiation and longer duration of breastfeeding has financial implications. Breastfeeding is associated with various health benefits for infants, including lower risk of diabetes, fewer instances of allergies and asthma, lower rates of respiratory illness, stronger immune systems, fewer ear infections, lower rates of Sudden Infant Death Syndrome, and fewer instances of Crohn's disease and colitis—all of which are illnesses or chronic conditions that entail increased medical expenses, including some that are quite costly over a lifetime.[120] Breastfed babies experience less illness and less hospitalization overall, resulting in reduced costs to parents, insurers, and the healthcare system.[121] Indeed, research shows that healthier outcomes from breastfeeding mean that parents have "up to six times less absenteeism from work."[122] In this way, investment in continuous labor support for

118. *See* BEY ET AL., *supra* note 8, at 5 ("Because the benefits are particularly important for those most at risk of poor outcomes, doula support has the potential to reduce health disparities and improve health equity.").

119. *See* Kozhimannil et al., *supra* note 115, at 20, 23 (noting the 22% percent lower odds of preterm birth associated with doula care and the resulting lower odds of facing "high costs of neonatal care and frequent hospitalizations").

120. *The Benefits of Breastfeeding for Baby & for Mom*, CLEVELAND CLINIC, https://perma.cc/2LB7-KH7D (last updated Jan. 1, 2018).

121. *Id.*

122. *Id.*

all birthing people would benefit not only birthing people and their families on an individual basis but also society more broadly.

III. THE STATUS OF DOULAS

Although women have long received care from experienced support people during childbirth, increasing demand for birth doula services and the accompanying professionalization of doulas have complicated the official status of doulas for the purposes of legal, institutional, and consumer recognition. This Part will describe the evolving status of doulas and highlight areas where doula status is contingent or contested.

A. *Licensure & Certification*

Doulas are not currently licensed or regulated in any jurisdiction in the United States. In various parts of the country, doulas, policymakers, and advocates are engaged in debates about implementing registration schemes for doulas, especially for the purposes of including doula reimbursement in state Medicaid plans.[123] Many doulas hold a national credential from a nationally-accredited certifying agency.[124] There are several prominent certifying agencies, including DONA International,[125] Birth Arts International,[126] and the International Childbirth Education Association,[127] but over 150 organizations currently train and certify doulas, with no standardization across the field.[128] Other doulas develop their skills more informally through apprenticeship and experience. At the federal level, the U.S. Department of Labor has classified doulas as paraprofessionals, applying the category of a "personal care and service worker."[129] Some doula advocates have

123. *See infra* Part III.D.

124. *See Evaluating Doula Certifications*, DOULAMATCH.NET, https://perma.cc/3CRC-Z2UJ.

125. DONA INT'L, https://perma.cc/C94L-GS7J.

126. *Certified Doula, Doula Certification*, BIRTH ARTS INT'L, https://perma.cc/6N2T-4XSZ.

127. INT'L CHILDBIRTH EDUC. ASS'N, https://perma.cc/9RDZ-JH6X.

128. *See Evaluating Doula Certifications*, *supra* note 124.

129. BUREAU OF LAB. STATS., DEP'T OF LAB., 2010 STANDARD OCCUPATIONAL CLASSIFICATION USER GUIDE 128 (2010), https://perma.cc/2EK5-FTA8 (PDF);

promoted embracing the designation of doula care as a paraprofession, given the various training routes doulas take, including performing doula work without any official training.[130]

B. *Traditional Doulas & Community-Based Doulas*

There is a distinction between the traditional doula model and community-based model of doula care, with important implications for access to doula support and health equity. All doulas learn anatomy and physiology related to childbearing; strategies for providing emotional support; skills for coping with labor; techniques for fostering effective communication between birthing people and their healthcare providers; basic principles of allopathic and holistic health care and various modalities for client referral to address specific needs as appropriate (such as acupuncture); and methods for supporting lactation and newborn feeding.[131] There are, however, important differences between traditional and community-based doulas, which include their respective scopes of practice, the method and amount of their compensation, the focus of their training, and the typical clientele served by each type of doula.

The traditional doula model encompasses birth (and sometimes postpartum) support that requires significant payment out of pocket and thus is accessible only to those birthing people with the resources to afford this kind of care.[132] The average rate for a birth doula falls between $800 and $2,500, depending on the location, the doula's experience, and the services provided.[133] A national survey of doulas (the "Lantz Study") found that in 2003, "only 10% of certified doulas

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see Paula M. Lantz et al., *Doulas as Childbirth Paraprofessionals: Results From a National Survey*, 15 WOMEN'S HEALTH ISSUES 109, 110 (2005).

130. *See, e.g.*, Amy Gilliland, *Doulas are Paraprofessionals*, DOULAING THE DOULA (May 31, 2016), https://perma.cc/V6L4-775S (noting that conceiving of doulas as a paraprofession "does *not* mean that the professionals [doulas] work alongside of [sic] can effectively do [their] job" because the "paraprofessional has specific skills and attributes that make it possible for the professional to accomplish more complex tasks and responsibilities").

131. *See* BEY ET AL., *supra* note 8, at 12.

132. *See id.* at 3.

133. Robin Elise Weiss, *The Cost of Hiring a Doula for Your Pregnancy*, VERYWELL FAM. (Sept. 13, 2021), https://perma.cc/8EUV-2TYC.

reported receiving third-party reimbursement for their services."[134]

Trainings prepare traditional doulas to provide unconditional, nonjudgmental support but usually lack engagement with human rights or reproductive justice principles that address the experiences of poor and marginalized birthing people.[135] Traditional doula trainings tend to emphasize entrepreneurial skills for doulas who intend to establish a private practice and earn a living by providing doula services.[136] Typical training under the traditional model includes sixteen hours of classroom time with trainers from the certifying organization who may live and work in a different geographic region.[137] Traditional doula organizations—and the workforce they train—are disproportionately White and have not historically prioritized the leadership or experiences of people of color or the needs of low-income communities.[138] Though dated, the Lantz Study found that, in 2003, birth doulas were primarily White, well-educated, married women with children.[139] Researchers reported that the majority of doulas worked in solo practice, serving an average of nine clients annually.[140]

In contrast, the community-based doula model prioritizes making doula services available to underserved communities.[141] In order to reduce barriers to accessing doula support, services are provided at low or no cost.[142] Community-based doula

134. Lantz et al., *supra* note 129, at 109.

135. *See* BEY ET AL., *supra* note 8, at 10 (noting the lack of "historical, educational cultural context on how race, institutional and interpersonal bias, and other social determinants play an integral role in birth disparities affecting communities of color" within traditional doula trainings).

136. *See id.*

137. *Id.*

138. *See id.*

139. Lantz et al., *supra* note 129, at 114.

140. *Id.* at 109.

141. *See* BEY ET AL., *supra* note 8, at 3.

142. *See id.* While some doulas work on a volunteer basis, community doula programs typically prioritize sustainability, seeking grant funding or private donations in order to compensate doulas for their work in accordance with a community health worker model. *See* HEALTHCONNECT ONE, SUSTAINABLE FUNDING FOR DOULA PROGRAMS: A STUDY 11 (2017), https://perma.cc/52VK-32B3 (PDF) [hereinafter SUSTAINABLE FUNDING FOR

practices are located in the communities they serve and often include a broader array of services than traditional doula care, including more home visits and referrals for people who need more extensive forms of social support.[143] Because community-based doulas are usually members of the communities they serve, these doulas and their clients share a common "background, culture, and/or language."[144]

Community-based doula trainings, which can include over one-hundred hours of programming,[145] cover not only comprehensive childbirth education and the skills for providing unconditional, non-judgmental support but also are rooted in an understanding of racism and discrimination, including the role of implicit bias in shaping perinatal healthcare experiences.[146] Community doulas are familiar with the concept of intergenerational trauma experienced by people of color and the impact of trauma-related stress on perinatal health outcomes, as well as human rights and reproductive justice principles, racism and health, and the life-course perspective as it relates to doula support.[147] Typical training for community-based doula programs include additional sessions that cover the impact of social determinants of health and the availability of resources to address particular client needs, such as transportation assistance, financial support, mental health services, substance abuse counseling, access to health insurance, housing

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DOULA PROGRAMS]. The HealthConnect One study found that 70% of community doula organizations relied on private foundation grants. *Id.*

143. *See* BEY ET AL., *supra* note 8, at 3.

144. *Id.*

145. Naima Black, Dir., Cmty. Doula & Breastfeeding Programs, Maternity Care Coal., PA Perinatal Quality Collaborative Doula Spotlight (June 11, 2020), https://perma.cc/2L97-J2TA (PDF).

146. *See* BEY ET AL., *supra* note 8, at 10–11; *see also* Kristina Wint et al., *Experiences of Community Doulas Working with Low-Income, African American Mothers*, 3 HEALTH EQUITY 109, 114 (2019) ("[D]oulas recognize the institutional biases that exist in the health care system and try to mediate their effect on birthing persons. . . . [N]ew evidence shows doulas, in providing emotional, physical, and tangible support, can help reduce the negative effects . . . on birthing persons.").

147. *See* BEY ET AL., *supra* note 8, at 10. In the context of doula support, a "life-course perspective" refers to the concept that "respectful maternity care includes reframing the experience of childbirth not as a single medical event, but as a series of experiences over a person's lifespan that transition the individual into parenthood." *Id.* at 11.

assistance, immigration assistance, environmental justice and toxic lead conditions, the process of making referrals to social support services, cultural humility and ability to recognize intersectional needs of birthing person, and trauma-informed care, among others.[148]

A 2017 study of ninety-eight community doula programs found that 80 percent were nonprofits, with many of the remaining organizations existing within a home visitation program.[149] The organizations had an average of ten doulas each and served between ten and three hundred pregnant people annually, with the majority serving between twenty and sixty clients each year.[150] Ninety-six percent of the organizations served women insured by Medicaid, and a majority of organizations served clients who were uninsured, undocumented, or both.[151] A major finding of the study was that funding for community doula programs fluctuates because of their heavy reliance on private foundations, which poses a threat to the sustainability of the organizations and their ability to fulfill their missions.[152]

C. *Hospital Credentialing*

Some hospitals require credentialing or an equivalent approval process for doulas, and others have instituted new credentialing requirements amidst the COVID-19 pandemic. Still other hospitals make effective doula support difficult or impossible to provide using informal mechanisms under circumstances discussed in Part IV.A. Some doula organizations have welcomed credentialing requirements as a sign that hospitals view doulas as professionals and recognize a role for doulas in the delivery room.[153] Others have expressed concern

148. *See id.* at 12–13.

149. SUSTAINABLE FUNDING FOR DOULA PROGRAMS, *supra* note 142, at 8.

150. *Id.* at 9.

151. *Id.*

152. *See id.* at 11.

153. *See Hospital "Credentialing" for Doulas? Yea or Nay?*, PRODOULA (Oct. 24, 2015), https://perma.cc/6AAW-48WG. ProDoula is a for-profit doula certification company that seeks to "rebrand doula work from a fundamental right to a luxury service." Katie J.M. Baker, *This Controversial Company Wants to Disrupt the Birth World*, BUZZFEED NEWS (Jan. 4, 2017, 11:24 AM), https://perma.cc/W6R2-UE87.

that the introduction of hospital credentialing infringes on the autonomy of birthing people by exerting control over doulas with the risk that fear of reprisal will prompt doulas to be less proactive in situations where they perceive that their clients' needs are not being met by clinical care providers.[154] There is also concern that the administrative and financial requirements associated with credentialing will exacerbate gaps in access to birth support for low-income birthing people and birthing people of color.

There is a variety of mechanisms and terms that hospitals use when they institute formal requirements for doulas to be able to support their birthing clients. Some hospitals classify doulas as "non-clinical dependent healthcare providers" or "allied health professionals."[155] Some hospitals use the language of "vendor credentialing," which can apply not only to representatives of the healthcare industry and other non-hospital employee vendors but also to allied healthcare providers who are not employed or supervised by the hospital or its physicians.[156] Hospitals have significant discretion when it comes to determining the level of credentialing required to work within the facility.[157]

The Joint Commission, an independent not-for-profit organization that accredits and certifies healthcare organizations in the United States, has not addressed vendor credentialing.[158] Joint Commission standards, however, are "relevant to any individual that enters a health care organization who directly impacts the quality and safety of

154. *See infra* Part III.C.2.

155. DONA INT'L, STATEMENT ON BIRTH DOULA CREDENTIALING 1 (2017), https://perma.cc/T728-DSJM (PDF) [hereinafter STATEMENT ON BIRTH DOULA CREDENTIALING]. DONA notes that the Association of Schools of Allied Health Professionals defines an allied health professional as "a 'specialist' who provides 'comprehensive patient-centered care,'" which would seem to exclude doulas, who are not providers of clinical or medical care. *Id.*

156. *Id.*

157. *See id.*

158. *See Joint Commission Bows Out of Vendor Credentialing Debate*, J. OF HEALTHCARE CONTRACTING, https://perma.cc/HH58-UEFB ("[T]he Joint Commission decided it was not in the business of developing standards of competence for healthcare industry representatives, that is, sales reps.").

patient care."[159] Relevant standards include those concerning knowledge of who is entering a facility and their purpose for being there,[160] the need to ensure that patient rights are respected[161] and that infection control precautions are followed,[162] and the development and implementation of a patient safety program.[163] Typically, the credentialing process for a dependent healthcare provider includes "registration of contact information, criminal background check, verification of training and certification, proof of malpractice insurance coverage, agreement to practice within the hospital-defined role of the provider, required attendance at hospital trainings or policy and procedure in-services, screening for infectious diseases and mandatory immunizations," drug screening, and payment of a fee.[164]

Doulas fit uneasily into the existing framework for hospital credentialing that typically applies to vendors and allied health professionals. Most importantly, doulas are not healthcare providers and do not come to hospitals to provide medical or clinical care. As paraprofessionals, they occupy a distinct role.[165] While certain concerns addressed by Joint Commission standards are relevant to doulas working in hospitals, such as prevention of infection and protection of patient safety, the same concerns would apply to any hospital visitor, including family members and other loved ones who come to visit an admitted patient. Prominent doula organizations have issued guidance

159. *Health Care Industry/Vendor Representatives*, THE JOINT COMM'N (Apr. 15, 2009), https://perma.cc/WE7J-YEAL (PDF).

160. *See Joint Commission Bows Out*, *supra* note 158 (citing JOINT COMM'N STANDARD EC.02.01.01 (THE JOINT COMM'N 2022)).

161. *Id.* (citing JOINT COMM'N STANDARD RI.01.01.01 (THE JOINT COMM'N 2022)).

162. *Id.* (citing JOINT COMM'N STANDARD IC.02.01.01 (THE JOINT COMM'N 2022)).

163. *Id.* (citing JOINT COMM'N STANDARD LC.02.02.05 EPs 1, 3–4 (THE JOINT COMM'N 2022)).

164. STATEMENT ON BIRTH DOULA CREDENTIALING, *supra* note 155, at 2–3; *see also* Boudin, *supra* note 14.

165. *See* STATEMENT ON BIRTH DOULA CREDENTIALING, *supra* note 155, at 2–3 ("Birth doulas are non-clinical providers of labor support services, which include emotional support, physical comfort, informational guidance and advocacy, independently hired by the parents and not the hospital, facility or institution.").

for doulas about how to evaluate credentialing requirements they encounter and whether to sign an agreement offered by a hospital, "invit[ing] doulas to carefully examine the potential effects" of entering into a hospital credentialing agreement.[166] In particular, DONA International—one of the oldest and most prominent doula certifying organizations—has declined to take a position on doula credentialing, stating that it "is committed to investigating this issue more thoroughly and welcomes further dialogue with all interested parties."[167] Other doula organizations have directly opposed credentialing requirements.[168]

1. Arguments in Favor of Hospital Credentialing

Many of the arguments in favor of hospital credentialing of doulas focus on the status and professional identity of doulas, although some also concern access to and the desirability of doula services. First, formal credentialing may signal recognition of doulas as fulfilling a distinct role in perinatal care, a role which goes unacknowledged when doulas are encompassed within a hospital's general visitor policy.[169] By differentiating between doulas and other patient visitors, hospitals recognize that doulas provide a unique and valuable service—as evidenced by a robust body of research on the benefits of continuous labor support.[170] Credentialing may also be an acknowledgement of the increasing professionalization of doulas, the existence of better and more robust training

166. *Id.* at 5; *see also id.* at 2.

167. *Id.* at 5; *see also id.* at 3.

168. *See, e.g.*, Clark, *supra* note 15 (expressing the position of Birth Arts International: "[These policies] prevent doulas from being able to support their clients. Many doulas work in multiple facilities, take income-based clients, and these new limitations to access [are] harmful to families and professional doulas. Doulas work for the family, not the care facility").

169. *See* Catie Mehl, *Hospitals Credentialing Doulas? Yes, Please!*, COLUMBUS BIRTH & PARENTING (Oct. 20, 2015), https://perma.cc/TB65-CCWB ("[W]e are not visitors. We are professional doulas. The requirements [of the doula credentialing policy] are no different than the requirements for anyone else who enters the hospital on a professional level.").

170. *See supra* Part II.

opportunities for doulas, and the greater number of doulas with formal training.[171]

In this light, formalization of doulas by hospital credentialing suggests an enhanced status; for doulas who resent being considered visitors, this is an appealing change.[172] In a practical sense, credentialing could mean doulas are able to secure a name badge and access the relevant floors of the hospital without having to be buzzed in by staff.[173] Relatedly, if credentialing means doulas no longer count as "visitors," it could increase the number of people a birthing person can have accompany them during labor and delivery (though hospitals could change their rules on visitors during labor and delivery to account for doulas separately).[174]

Credentialing could improve doulas' ability to market themselves and expand their client base. Being credentialed at a local hospital might be a selling point for potential clients, signaling experience with providers, protocols, and practices at that facility.[175] To the extent that pregnant people falsely understand doulas to be appropriate or useful only for those planning community births (at home or in a birth center) or unmedicated hospital births, a hospital credential may increase the use of doulas by birthing people planning to deliver in a hospital, including people who intend to have an epidural for pain relief.[176] Some hospitals contract with doulas to provide services for their patients in a fee-for-service capacity.[177] If this is a desirable model for expanding access to doula care, hospitals should be encouraged to see doulas as part of the workforce with whom they contract, and credentialing is a step in that

171. *See Hospital "Credentialing" for Doulas? Yea or Nay?*, *supra* note 153.

172. *See id.* ("Imagine how much patient satisfaction would increase if the doula were recognized by the hospital as a professional support person, someone who [complements] the professional medical staff charged with caring for the health of the pregnant person and their baby.").

173. *See, e.g.*, *id.*

174. *Id.*

175. *See id.* ("'Do you get along well with the nurses at the hospital I'm birthing at?' This is a question I am asked at every single interview. A hospital credential would remove the need for this question.").

176. *See id.*

177. *See, e.g.*, *Birth Doula Services*, SWEDISH HEALTH SERVS., https://perma.cc/8AE5-QAFU.

direction.[178] Finally, credentialing might bring enhanced accountability for doulas who improperly engage in activities outside the scope of their practice by giving hospitals a more formal oversight role and the ability to sanction doulas through withdrawal of a credential.[179]

2. Arguments Against Hospital Credentialing

Arguments against hospital credentialing tend to focus on preserving clarity about the role of a doula and the doula's independence as a support person focused on the pregnant person's interests and needs, as well as concerns about access—both in terms of who is able to work as a doula and the ability of a pregnant person to use their chosen doula. Credentialing may obscure the role of the doula by suggesting to birthing people that doulas are part of the hospital team, making it harder for patients to distinguish between the roles of midwife, nurse, and doula. By formalizing the status of doulas, credentialing increases the power of hospitals to determine who can be in the delivery room, which advocates argue is a decision that should belong to the birthing person who knows best what kind of support they need and who is best suited to provide such support.[180] Fear of reprisal and retaliation may chill a doula's ability to speak up when witnessing provider coercion or other forms of mistreatment, reducing the doula's effectiveness as a source of provider accountability—which for some birthing people is a motivating factor for securing doula support in the first place.[181] Relatedly, credentialing may create a conflict of

178. Some birth advocates might argue that independence is important for a doula to work effectively and provide patient-centered support, suggesting that the ideal model for expanded access to doula care is not universal hospital-based doula provision but rather investment in an expanded independent doula workforce.

179. *See Hospital "Credentialing" for Doulas? Yea or Nay?*, *supra* note 153 ("There is accountability [in asking doulas to sign a hospital scope of service]. Agree to this scope of service. Sign the document saying you agree and if you practice out of scope, you don't come back. Easy, right?").

180. *See* STATEMENT ON BIRTH DOULA CREDENTIALING, *supra* note 155, at 2 ("It is possible that a Credentialing Agreement will limit the choices of parents as to the doulas they can choose.").

181. *See* Best, *supra* note 24, at 176 ("[M]any modern women feel the need to hire a professionally trained advocate . . . to assert their rights during labor and delivery and to prevent abuse and unwanted medical procedures.").

interest for the doula, who is beholden both to the hospital in order to maintain the credential and to the client who hired the doula to provide specific services.[182] Credentialing may also suggest endorsement of hospital policies and practices, which some doulas critique as lacking support.[183]

Credentialing may exclude doulas who lack formal certification by an accrediting agency or who work on a volunteer basis, which likely would disproportionately impact community-based doulas serving low-income birthing people

182. *See* Boudin, *supra* note 14 (interviewing Charlotte-area doulas who refused to comply with a major area hospital's new policy requiring doulas to register in order to avoid the potential of "answer[ing] to the hospital first and [the patient] second").

183. This concern reflects a point of tension between doulas practicing in different areas and serving different clients. *Compare* Mehl, *supra* note 169 ("What better way to show expecting families that we not only support hospital birth, but we also *respect* the guidelines their chosen hospital has in place for other professionals and we adhere to them ourselves?" (emphasis in original)), *with Evidence-Based Care*, ATX DOULAS, https://perma.cc/2AQ2-AY65 (explaining to prospective clients that "many hospital procedures go in direct contrast to recent medical evidence, and increase the risks for healthy mothers and babies"). As further illustration of this concern, language from an Alabama hospital's "Doula Partnership Agreement" states, "[W]e have minimal standards of care that must be met, for example, regarding IV access and fetal monitoring. These policies are not negotiable, and attempts to undermine these policies are not acceptable. This is crucial in fostering an environment of mutual respect between the medical team and the doula." Doula Partnership Agreement, UAB Women & Infants Center, https://perma.cc/36ZX-MPKJ (PDF). Hospitals that require continuous electronic fetal monitoring are not following the best available evidence on monitoring fetal heart tones during labor. *See* Zarko Alfirevic et al., *Continuous Cardiotocography (CTG) as a Form of Electronic Fetal Monitoring (EFM) for Fetal Assessment During Labour (Review)*, 2019 COCHRANE DATABASE OF SYSTEMIC REVS., Feb. 3, 2019, at 1, 1–2 (finding that continued CTG during labor is associated with increased caesarean sections and instrumental births); Thomas P. Sartwelle et al., *A Half Century of Electronic Fetal Monitoring and Bioethics: Silence Speaks Louder Than Words*, MATERNAL HEALTH, NEONATOLOGY, & PERINATOLOGY, Nov. 21, 2017, at 1, 4 (describing a "dramatic increase in C-sections due to EFM's 99% false-positive rate"); Part IV.B.4. *See generally* HENCI GOER & AMY ROMANO, OPTIMAL CARE IN CHILDBIRTH: THE CASE FOR A PHYSIOLOGIC APPROACH (2012). Under language like the Alabama hospital's agreement, however, a doula who provides this information to a client and affirms the client's decision to request intermittent fetal monitoring instead—enabling her to remain mobile during labor, shifting positions during contractions and taking advantage of gravity—will be deemed to have violated the policy and may be at risk of being removed from the delivery room.

and birthing people of color.[184] The cost of certification fees is financially prohibitive for some doulas.[185] Credentialing would also likely exclude doulas with history in the criminal legal system, which interferes with birthing people's choice of support person and may disproportionately impact doulas of color, given the overrepresentation of people of color in the criminal legal system.[186] Applying for a hospital credential requires disclosure of personal information to hospital authorities, which may feel unsafe for some individuals, including people without formal immigration status.[187]

Hospitals may require doulas to adhere to a limited scope of service as part of the credentialing agreement, which could

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184. *See* Amy Gilliland, *Doulaing the Doula Toolkit for Gaining Entry to Hospitals*, DOULAING THE DOULA (Feb. 9, 2021), https://perma.cc/8KSJ-WWUK ("Certification is not a beginning doula achievement. It is a goal one achieves after establishing their career—if at all."); *see also* Bentley Portfield-Finn, *What Does It Mean to Decolonize Birth?*, MOTHERLOVE, https://perma.cc/5C84-QWBA (discussing licensure and credentials as colonizing practices that exclude "various cultural traditions surrounding birth and postpartum" and replacing them "with a tightly regulated hospital environment); *About Ancient Song*, ANCIENT SONG DOULA SERVS., https://perma.cc/8QQV-NP2X (describing how Ancient Song works to achieve its mission by "[t]raining community members to become full-spectrum doulas" and "[p]roviding direct doula services to low-income people of color"). Additionally, some hospitals require that doulas be paid professionals, even in the absence of a credentialing requirement. *See, e.g.*, Cathy Williams, *COVID-19 and Pregnancy*, LAKEVIEW REG'L MED. CTR., https://perma.cc/5Q8C-6F8H (noting that in addition to a single named support person of choice, a "mother may also have a paid professional doula at her side for the duration of labor and delivery").

185. *See* Gilliland, *supra* note 184

> Certification with an organization like DONA International is considered expensive by many doulas. Since it is not required and there may be financial barriers, when hospitals require certification for access it then becomes an *equity* issue. In other words, since certification is often out of reach for financial reasons for otherwise qualified doulas, requiring it means that you are placing a financial burden on the doula. If that burden is insurmountable and the doula is a person of color, it has the effect of being *racially inequitable*.

186. *See* ELIZABETH HINTON ET AL., VERA INST. OF JUST., AN UNJUST BURDEN: THE DISPARATE TREATMENT OF BLACK AMERICANS IN THE CRIMINAL JUSTICE SYSTEM 2 (2018), https://perma.cc/6DN6-R9JV (PDF).

187. *See What Is Hospital Credentialing?*, VERISYS (Dec. 8, 2021), https://perma.cc/2NZG-FQ2Z (noting that credentialing can require a doula to provide a driver's license or Social Security card or undergo a background check).

preclude doulas from being able to support clients at home during early labor or from supporting clients at other facilities where they are not credentialed.[188] This infringes on doula autonomy and limits the positive impact doulas can have in improving birth outcomes, while also limiting consumer choice of birth support person. Ultimately, credentialing would restrict choice for consumers, who are limited to working with doulas approved by their hospital. This may mean going without support from the doula deemed by the birthing person to be most aligned with their values and communication style.

Disagreement among doulas regarding the potential costs and benefits of formal hospital recognition reflects diversity among the doula workforce and the clients they serve. Race, class, gender, education, and previous medical history (among other factors) lead to differing levels of patient trust in their providers, different experiences with the quality of communication between patients and providers, and varying degrees to which patients experience respectful perinatal care.[189] While some birthing people may prefer their doulas to be well integrated into the hospital system,[190] other birthing people hire a doula specifically to act as a buffer and safeguard against provider mistreatment and other negative care experiences—in short, to be on their team.[191] Not surprisingly, opinions about the desirability of doula credentialing are similarly diverse.[192]

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188. *See* STATEMENT ON BIRTH DOULA CREDENTIALING, *supra* note 155, at 5.

189. *See, e.g.*, Jacquelyn Clemmons, *Life or Death: The Role of Doulas in Improving Black Maternal Health*, HEALTHLINE (Apr. 29, 2020), https://perma.cc/6YHM-YUDF (describing the "lack of care and disregard" characterizing a Black mother's experiences in hospitals during pregnancy and birth),

190. *See* Tara Haelle, *What Is a Doula? And Do You Need One?*, N.Y. TIMES (Apr. 15, 2020), https://perma.cc/C8BQ-87FP (noting that doulas can be "especially helpful when they understand how health systems, obstetricians and midwives work").

191. *See* Clemmons, *supra* note 189 ("Black maternal and perinatal health are affected by many factors. Having a strong birth support team that is invested in positive outcomes for your family is imperative. Addressing systemic bias and cultural incompetence is a must.").

192. For example, the author of a post on behalf of ProDoula stated, "For obvious reasons, hospitals must protect themselves from anyone 'working' in their facility that could cause a difficult or dangerous circumstance." *Hospital "Credentialing" for Doulas? Yea or Nay?*, *supra* note 153. Other doulas have

D. *Recognition for Medicaid Coverage*

Concerned about the high out-of-pocket cost of doula services and the resulting gaps in access to doula support, advocates in various states have launched campaigns to secure Medicaid coverage for doula services.[193] The push to secure Medicaid reimbursement for doula services reflects recognition of the benefits to low-income women of receiving continuous support during childbirth.[194] Medicaid covers over 40 percent of all births in the United States; in 2019, 65 percent of births to non-Hispanic Black women and 59 percent of births to Hispanic women were paid for by Medicaid.[195] Currently, Medicaid covers birth doula services in Oregon, Minnesota, Indiana, and New

noted that when powerful hospitals have wide discretion to enforce exclusionary policies, implicit (or explicit) bias can lead to disproportionately punitive action taken against doulas perceived to be problematic due to their race, class, or another identity. *See generally* Juan L. Salinas et al., *Doulas, Racism, and Whiteness: How Birth Support Workers Process Advocacy Toward Women of Color*, 12 SOCIETIES 1, 11–12 (2022) (discussing Black doulas' experiences with "racial stereotyping and mistreatment from medical personnel and staff"). While it may appear "obvious" to some that difficult people should be excluded from hospitals, a doula who is helping her client advocate for herself with a provider acting coercively to push an unwanted intervention on the patient might also be deemed "difficult" and removed. *See* Suein Hwang, *As 'Doulas' Enter Delivery Rooms, Conflicts Arise*, WALL ST. J. (Jan. 19, 2004), https://perma.cc/MM4B-R3AN. Given that people of color experience provider mistreatment during childbirth at disproportionate rates, *see supra* note 83, it is likely that the doulas who support birthing people of color—often themselves people of color—are at a greater risk of running afoul of credentialing agreements that afford hospitals significant latitude in enforcement. *See* Vedam et al., *supra* note 80, at 1 (noting that obstetric mistreatment of patients of color giving birth at hospitals can be "exacerbated . . . by patient-provider disagreements").

193. *See, e.g.*, Corrinne Hess, *Milwaukee Plans to Provide Doulas to 100 Women*, WIS PUB. RADIO (Mar. 20, 2019, 6:00 AM), https://perma.cc/XFR4-AKSX.

194. *See id.* ("Doula services have shown to lessen stress and anxiety, reduce cesarean surgery rates and support higher rates of breastfeeding, according to the Wisconsin Doulas of Color Collective.").

195. JOYCE A. MARTIN ET AL., U.S. DEP'T OF HEALTH & HUMAN SERVS., NCHS DATA BRIEF NO. 387, BIRTHS IN THE UNITED STATES, 2019 1, 3 (2020), https://perma.cc/AYV7-M9UR (PDF).

York,[196] although Indiana's program is not yet funded[197] and New York's is a pilot program operating only in Erie County and parts of Brooklyn.[198] In some states, doula services are available as a free benefit through a Medicaid Managed Care plan.[199] Many other states are considering proposed legislation to implement Medicaid coverage of birth doula services, with thirty-one bills introduced as of May 2021.[200]

Of the nearly four million people who give birth each year, only roughly six percent have doula support while giving birth.[201] In addition to expanding doula access to birthing people who would otherwise be unable to pay out of pocket for doula services, securing Medicaid reimbursement for doula services has the potential to expand the ability of doulas to build successful careers providing doula care.[202] But this possibility

196. KATHY GIFFORD ET AL., KAISER FAM. FOUND., MEDICAID COVERAGE OF PREGNANCY AND PERINATAL BENEFITS: RESULTS FROM A STATE SURVEY 4 (2017), https://perma.cc/PUB7-EX6Y (PDF).

197. Christina Gebel & Sara Hodin, *Expanding Access to Doula Care: State of the Union*, HARVARD CHAN SCH.: MATERNAL HEALTH TASK FORCE BLOG (Jan. 8, 2020), https://perma.cc/5PC7-AU9Z.

198. *New York State Doula Pilot Program*, N.Y. STATE DEP'T OF HEALTH, https://perma.cc/N99H-PBW3; Quinn, *supra* note 102; *see also* Renee Mehra et al., *Recommendations for the Pilot Expansion of Medicaid Coverage for Doulas in New York State*, 109 AM. J. PUB. HEALTH 217, 217–18 (2019).

199. *See, e.g.*, *How a Doula Can Make a Difference*, TUFTS HEALTH PLAN, https://perma.cc/2FUU-UYDV (describing the Doula By My Side program, which began as a pilot in Worcester, Massachusetts, in 2015 as a collaboration with the Pettaway Pursuit Foundation and has since expanded in Massachusetts and Rhode Island); Alexis Robles-Fradet, *Medicaid Coverage for Doula Care: State Implementation Efforts*, NAT'L HEALTH L. PROGRAM (Dec. 8, 2021), https://perma.cc/UC7A-KNJX (noting the Florida Agency for Healthcare Administration's inclusion of doula services as an expanded benefit that Medicaid managed care organizations can include, providing discretion to individual plans on whether and how to implement this benefit).

200. *Current State Doula Medicaid Efforts*, NAT'L HEALTH L. PROGRAM, https://perma.cc/4824-W6HV.

201. DECLERCQ ET AL., *supra* note 70, at 16. Even if the percentage of people receiving doula support has increased since the last Listening to Mothers survey, it is likely still less than ten percent of birthing people who use doulas.

202. *See* Rachel R. Hardeman & Katy B. Kozhimannil, *Motivations for Entering the Doula Profession: Perspectives from Women of Color*, 61 J. MIDWIFERY & WOMEN'S HEALTH 773, 779 (2016) (calling for policy strategies to "reduc[e] financial barriers to entry [to] allow women of color to train as a cohort" and "ensur[e] adequate reimbursement of services to allow low-income women to maintain doula careers serving women in their own communities").

depends on how states set reimbursement rates for doula services in their Medicaid plans. Some early proposals for inclusion of doulas in Medicaid included reimbursement rates far below a living wage, making it impossible for anyone who lacks additional sources of income or family support to sustain a meaningful client load through the Medicaid program.[203]

For example, in Oregon, which in 2013 became the first state to include birth doula services in its Medicaid program, doulas who register as Traditional Health Workers can bill for a total fee of $350 under fee-for-service Medicaid (two prenatal and two postpartum visits at $50 per visit and $150 for intrapartum care).[204] As of 2018, only 121 claims for doula services had been submitted, which Oregon doulas say is the result of low reimbursement rates and barriers in the billing process that have deterred widespread participation.[205] In 2018, four years after Minnesota implemented Medicaid reimbursement for doula services, the legislature acted to increase Medicaid reimbursement rates in order to increase utilization of services, raising the rates to $47 per home visit and $488 for intrapartum care[206]—although the bill was vetoed by the governor.[207] A report analyzing New York's proposal for statewide Medicaid reimbursement concluded that the rates for home visits would constitute the equivalent of $8.17 per hour without benefits, far below New York City's minimum wage.[208] Advocates say low reimbursement rates will limit doula participation in Medicaid reimbursement and limit the ability of such programs to reach low-income pregnant people who

203. *See* Mehra et al., *supra* note 198, at 217 (noting that "[u]ptake has been minimal" for Medicaid coverage of doula services in Oregon and Minnesota "because reimbursement rates are below the cost for doulas to provide services"); BEY ET AL., *supra* note 8, at 21 (reporting that New York's "low rates are a deterrent to [doulas'] participation in the Medicaid pilot").

204. BEY ET AL., *supra* note 8, at 15 (noting that some Oregon doulas are able to negotiate higher rates with Medicaid Managed Care plans).

205. *Id*. at 16.

206. *Id*.

207. *Id.*

208. *Id*. at 21 (noting that the proposed rate would be the equivalent of a full-time job that pays only $5.58 per hour plus benefits). The report also noted that community doulas "spend six to eleven times as much time with clients as do health care providers working in a hospital or clinic setting." *Id*.

would benefit from doula support.[209] Other program design questions include the legal status of doulas (whether under a registration scheme, licensure, or some other status), the requirements for acceptance into the Medicaid program (certification, apprenticeship, etc.), and the requirement to carry malpractice insurance.[210]

Aspiring doulas confront a variety of decisions about training, certification, whether to operate independently or as part of an organization, whom to serve, and whether to participate in institutional arrangements such as hospital credentialing or Medicaid reimbursement programs that may expand or limit their ability to support their clients. Likewise, policymakers and other stakeholders must understand the current legal status of doulas, the different types of doulas, and what constitutes fair compensation for the hours that doulas invest in supporting their clients.

IV. NO SUPPORT FOR BIRTH SUPPORT

As noted previously, only a small percentage of birthing people take advantage of doula support when preparing for and then having a baby.[211] Access to doulas is limited by cost factors: for some birthing people it is simply a service they cannot afford in the absence of insurance coverage.[212] Others lack doula support because they are unaware that it is an option.[213] In addition, hospitals and hospital-based providers have instituted a variety of barriers to doula support, including outright

209. *Id*. at 17–18. New York's proposed reimbursement rates also fall far short of what doulas practicing in three community doula programs in Kings County (Brooklyn) are able to earn through a combination of private grant funding and federal funding. *Id*. at 21–22. Medicaid funding would provide a more sustainable basis for making doula services available to low-income pregnant people, but this approach is viable only if doulas can earn a living wage while participating in Medicaid.

210. *See* AMY CHEN ET AL., NAT'L HEALTH LAW PROGRAM, BUILDING A SUCCESSFUL PROGRAM FOR MEDI-CAL COVERAGE FOR DOULA CARE: FINDINGS FROM A SURVEY OF DOULAS IN CALIFORNIA 37–38 (2020), https://perma.cc/36BL-7RFF (PDF).

211. *See supra* note 201 and accompanying text.

212. *See, e.g.*, BEY ET AL., *supra* note 8, at 3.

213. *See* DECLERCQ ET AL., *supra* note 70, at 16 (noting that 25 percent of women in a major study were unaware that doula support was an option).

exclusion of doulas from the delivery room.[214] In practice, this may be effectuated by telling patients the physician has a "no doula policy" and that if they wish to have doula support during the birth, they should find a different physician. In certain geographic locations, and depending on how far along the pregnancy is, the birthing person may have no option but to remain with the doula-hostile physician for the remainder of the pregnancy and childbirth because there are no accessible provider options available as an alternative.

Doulas also face exclusion in informal and subtle ways; for example, they might be able to be present in the delivery room but experience hostility from nurses and physicians, find themselves ignored by providers, have their qualifications or experience challenged, or witness their clients being punished through rough treatment or disrespectful care for having a doula and attempting to advocate for themselves.[215] Subpart IV.A will identify three reasons why some hospitals and hospital-based providers perceive doulas as threatening and work to exclude them, and Subpart IV.B will explore how resistance to doula participation in hospital birth highlights several important and problematic aspects of childbirth in the United States.

A. *Why Hospital Doulas Face Restrictions*

1. Liability Concerns

In some instances, resistance to having doulas in the delivery room stems from concerns about liability and the idea

214. *See, e.g.*, Anna Claire Vollers, *Alabama OBGYN Refuses to Work With Birth Doulas, Causing Online Uproar*, AL.COM (Aug. 15, 2019, 6:41 PM), https://perma.cc/GB4L-27VS (last updated Aug. 15, 2019, 7:23 PM) ("[A] sign advised patients that [a local obstetrician] would no longer collaborate with doulas.").

215. *See* Papagni & Buckner, *supra* note 95 (detailing nurse resentment and animosity toward doulas); Kaylee S. Wolfe, "A Doula Can Only Do So Much": Birth Doulas and Stratification in United States Maternity Care 64 (2015) (B.A. thesis, Bowdoin College) (on file with Bowdoin Digital Commons, Bowdoin College) (describing how some doulas experience "power struggles, tension, resentment, or outright animosity" when working with nurses); JENNIFER GONZALEZ & MARIS GELMAN, HEALTH LEADS NETWORK, BARRIERS AND OPPORTUNITIES: DOULA CARE IN THE AGE OF THE PANDEMIC 4 (2021), https://perma.cc/4F34-PWGB (PDF) (recounting a racially-charged "combative episode" between a doula and hospital staff who tried to prevent the doula from accompanying her laboring patient upon admission).

that having a doula observing during labor and delivery may increase the risk of a healthcare provider being sued. Fear of malpractice lawsuits has also been cited to justify prohibitions on birth photography or videography, an increasingly common feature in modern childbirth.[216] Obstetricians do face the highest rates of medical malpractice of any medical specialty and experience high payouts by their insurance carriers.[217] In recent decades, malpractice risk in obstetrics has been blamed for declining interest in the specialty among aspiring physicians and for early retirements that have contributed to a workforce shortage.[218] But research shows that physicians overestimate their risk of being sued, as well as the likelihood of an insurance payout on their behalf.[219]

Although the impact of malpractice liability looms large in obstetrics, there is no basis to conclude that doula involvement increases the likelihood of a provider being sued or experiencing a payout by their insurer. It is unclear to what extent doulas have ever been subpoenaed to testify in medical malpractice cases, and there is no support for the idea that doula-assisted

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216. *See* Katharine Q. Seelye, *Cameras, and Rules Against Them, Stir Passions in Delivery Rooms*, N.Y. TIMES (Feb. 2, 2011), https://perma.cc/X8KG-Q4KZ.

217. *See* Victoria L. Green, *Liability in Obstetrics and Gynecology*, *in* LEGAL MEDICINE 441, 441 (S. Sandy Dunbar & Marvin H. Firestone eds., 7th ed. 2007) ("Nearly 77% of obstetrician/gynecologists have been sued at least once in their career and almost half have been sued three or more times."); James Gibson, *Doctrinal Feedback and (Un)Reasonable Care*, 94 VA. L. REV. 1641, 1674 (2008) ("[O]f all obstetric and gynecology cases, those involving labor and delivery produce the most plaintiff verdicts and result in the highest jury awards in all of medical malpractice (a median of $2.25 million)." (citations omitted)).

218. *See* Jennifer Silverman, *Malpractice Crisis Blamed; Fewer U.S. Seniors Match to OB.GYN. Residency Slots: The Fill Rate for this Group Falls to 65.1%*, OB/GYN NEWS, Apr. 1, 2004, https://perma.cc/8UQP-U4PV ("A recent professional liability survey of 2,185 ACOG fellows found that 1 in 7 have stopped practicing obstetrics because of the risk of liability claims . . . ."); WILLIAM F. RAYBURN, THE OBSTETRICIAN-GYNECOLOGIST WORKFORCE IN THE UNITED STATES: FACTS, FIGURES, AND IMPLICATIONS 2017, 101 (2017) ("[T]he average age at which ob-gyns stopped providing obstetric care was 48 years . . . ."); *see also id.* at 121–22.

219. *See* Ann G. Lawthers et al., *Physicians' Perceptions of the Risk of Being Sued*, 17 J. HEALTH POL., POL'Y & L. 463, 469 tbl.1 (1992) (finding that physicians practicing high-risk specialties such as obstetrics overestimate their chances of being sued by a factor of 1.6).

pregnant people are more likely to sue their physicians. As such, liability concerns associated with doula support seem unjustified and misguided. In fact, doula assistance may actually reduce the likelihood of a subsequent legal claim against a provider. Research shows that patients are more likely to sue their providers when there was poor physician-patient communication during clinical care.[220] One role for a doula is to help facilitate such communication by supporting the birthing person in knowing what questions to ask in order to understand the care provided. This suggests that doula-assisted patients are likely to have *better* communication with their physicians than if they were laboring without doula support. Furthermore, more efficient labors, fewer interventions, and a lower cesarean rate are positive health outcomes associated with continuous labor support by a doula—all of which reflect positively on the physician of record and the hospital and should neutralize any suggestion that doulas increase the risk of incurring malpractice liability.

2. Loss of Provider Control

Providers who resist shared decision-making as part of their clinical practice may worry that doula involvement means they will lose control over the flow of information in the delivery room and not be able to decide what the patient is told about risks and benefits of a proposed intervention.[221] This loss of control—sometimes characterized as "having too many cooks in the kitchen"—might engender hostility towards doulas. Ultimately, a model where physicians, nurses, and doulas work

220. *See* Kukura, *Obstetric Violence*, *supra* note 81, at 771–72 ("Patients who are frustrated with brief, rushed appointments and who believe their physicians show insufficient attention are . . . more likely to sue, as are patients who perceive their physicians to be patronizing them by providing insufficient detail or glossing over medical explanations."); Wendy Levinson, *Physician-Patient Communication: A Key to Malpractice Prevention*, 272 JAMA 1619, 1619–20 (1994) (discussing factors identified in a study of deposition transcripts from obstetric malpractice cases, including the devaluation of patients' views, poorly delivered information, and failure of physicians to understand patients' perspectives).

221. *See* Am. Coll. of Obstetricians & Gynecologists Comm. on Ethics, *ACOG Committee Opinion No. 819: Informed Consent and Shared Decision Making in Obstetrics and Gynecology*, 137 OBSTETRICS & GYNECOLOGY e34, e36 (2021) [hereinafter *ACOG Committee Opinion*].

together to get the patient all the information they need and help to facilitate their decision-making is the preferred approach.[222] Physicians who do not practice according to the principles of truly informed consent and shared decision-making may simply never embrace the presence of a support person who has the trust of the patient.

To the extent a physician's concerns about "too many cooks in the kitchen" reflect experiences where doulas have overstepped into medical diagnosis, treatment, or counseling beyond the scope of practice for doulas, the physician may have a legitimate concern about the potential for confusion and possible delay in the event of a time-sensitive clinical decision.[223] But there are other mechanisms for addressing inappropriate or unethical behavior on the part of a doula short of complete exclusion. This might include a one-on-one conversation between the physician and doula outside the context of the birth to clarify roles, or the inclusion of doulas in hospital in-service training to understand and discuss the distinct clinical and nonclinical roles for physicians and doulas—strategies that would foster greater interprofessional communication more generally.[224] Finally, if the conduct were sufficiently serious, the provider could report a certified doula to their certifying agency for investigation and sanction.[225]

3. Provider Attitude

For some providers, it is simply uncomfortable to have someone else knowledgeable in the room, which means that instead of viewing doulas as a valuable supplement to the

222. *See* Laura Lucas & Erin Wright, *Attitudes of Physicians, Midwives, and Nurses About Doulas: A Scoping Review*, 44 AM. J. MATERNAL CHILD NURSING 33, 36 (2019).

223. *See* Kira Neel et al., *Hospital-Based Maternity Care Practitioners' Perceptions of Doulas*, 46 BIRTH 355, 357 (2019) ("The most common negative or 'adversarial' interactions reflected the perception or experience of doulas' interference with clinical decision-making, including doulas who misinterpreted medical rules or were unaware of patients' medical complexity. Some practitioners described doulas obstructing or delaying medical care and damaging the practitioner-patient relationship.").

224. *See id.* at 358–59.

225. *See generally, e.g.*, DONA INT'L, ETHICS COMMITTEE'S PROCEDURE FOR LODGING AN OBJECTION (2018), https://perma.cc/6TCY-GYA7 (PDF).

clinical team, they perceive doulas as threatening.[226] Although the job of the doula is to focus on the nonclinical needs of the laboring person, physicians may perceive the doula as looking over the provider's shoulder and watching for provider mistakes.[227] Because they are repeat players, doulas can compare the quality of care across providers, which may present an uncomfortable form of accountability for some physicians.[228]

In fact, developers of a new app called IRTH have developed software to collect feedback from patients and their doulas about care experiences at different hospitals, focusing on the experiences of birthing people of color, especially Black people.[229] Given high rates of mistreatment and adverse health outcomes among patients of color, the developers hope to use horizontal information-sharing to apply consumer pressure to hospitals and providers to change their practices.[230] A doula's familiarity with the clinical environment of a specific hospital or the practice style of a particular physician might function in a similar way to distribute useful information horizontally to consumers—to the detriment of physicians and hospitals who have poor track records regarding patient experience. The type of accountability doulas provide may be destabilizing to some providers, who seek to neutralize the threat to ego and status that doulas represent simply by being present.

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226. *See* Neel et al., *supra* note 223, at 359 (noting that practitioners "may experience doulas' suggestions or presence as a challenge to their authority and expertise").

227. *See id.* ("Doulas were seen by some practitioners as markers of patient dissatisfaction with hospital care.").

228. *See* Nora Ellman, *Community Based Doulas and Midwives: Key to Addressing the U.S. Maternal Health Crisis*, CTR. FOR AM. PROGRESS (Apr. 14, 2020), https://perma.cc/C775-CKFL.

229. Bernadette Giacomazzo, *Kimberly Sears Allers Created an App for Black Mothers to Rate Their Doctors for Optimal Health*, AFROTECH (Mar. 3, 2021), https://perma.cc/6RPC-NRAA.

230. *See Birth, But We Dropped the B for Bias*, IRTH, https://perma.cc/MVC8-YA4P

> For too long, the medical system has operated without transparency or any public accountability, particularly to Black women who are disproportionately dying in hospital settings during and after childbirth. Our back-end database[] turns your qualitative experiences into quantitative data to identify patterns and behaviors, as we leverage the collective power of Black and brown consumers to push for social change.

B. *What Resistance to Doulas Reflects About Modern Childbirth*

1. Influence of Liability on Clinical Decision-Making

As discussed previously, fear of malpractice liability is a feature of obstetrics practice, with physicians paying high malpractice insurance premiums and birth injury lawsuits that result in high monetary awards to injured parties.[231] Research shows that defensive medicine influences clinical decision-making in obstetrics, even if only subconsciously.[232] But fear of liability exposure is disproportionate to the actual likelihood of being sued or having an insurer pay an award on a physician's behalf.[233] Physicians' skewed perceptions of malpractice risk drive fetal-consequentialist decision-making because while obstetrics is notorious for high malpractice awards, successful claims are virtually all related to injuries to the baby, not to the birthing person.[234] Physicians do not incur liability for performing an unwanted and unneeded cesarean, regardless of lasting injury, pain, or suffering to the birthing person,[235] but liability can result from failure to intervene soon enough.[236] This orients providers towards intervention as a liability-minimizing technique and can contribute to physician

231. *See supra* Part IV.A.1.

232. *See, e.g.*, Laura D. Hermer & Howard Brody, *Defensive Medicine, Cost Containment, and Reform*, 25 J. GEN. INTERNAL MED. 470, 470 (2010) ("93% of 'high-risk' specialists in Pennsylvania reported practicing defensive medicine. A 2008 study elicited a comparable reply from 83% of Massachusetts physicians." (citations omitted)); *see also* MASS. MED. SOC'Y, INVESTIGATION OF DEFENSIVE MEDICINE IN MASSACHUSETTS 5 (2008), https://perma.cc/ZH2E-B5C8 (finding that 35% of obstetrician-gynecologists "said that liability concerns affected the care they provided 'a lot'").

233. Lawthers, *supra* note 219, at 469 tbl.1.

234. *See* Nadia N. Sawicki, *Fetal Consequentialism and Maternal Mortality*, BILL OF HEALTH (May 16, 2017), https://perma.cc/F2PP-FPNB ("Fetal consequentialism is likely driven not only by providers' judgments of the relative liability risks for harms to fetuses versus harms to mothers, but also by conservative societal trends . . . that preference fetal interests over maternal interests."); Kukura, *Obstetric Violence*, *supra* note 81, at 784–85 ("[I]n those rare instances where women have prevailed on claims brought for injuries suffered during childbirth, it is typically through a fetal injury derivative claim.").

235. Kukura, *Obstetric Violence*, *supra* note 81, at 784.

236. *Id.* at 773 n.339.

unwillingness to abide by a patient's informed refusal of treatment, particularly regarding cesarean surgery.[237] While this phenomenon is certainly not universal in obstetrics, fetal-consequentialist decision-making driven by fear of liability has had devastating effects for some birthing people.[238]

Provider desire to control who is present in the delivery room reflects anxiety about liability exposure, whether literally to avoid having an additional witness in the event negligence occurs (and particularly a witness who has more information than the average patient about the standard of care and is likely to recognize when a provider violates that standard) or out of a deeper need to try control the chaos of childbirth in order to produce a positive outcome. The latter concern reflects a fundamental feature of modern obstetrics: a preoccupation with eliminating fetal risk through active management of childbirth and use of technology.[239] This orientation towards risk shapes clinical decision-making and provider willingness to push interventions.[240] But no amount of technology or intervention can eliminate all risk from childbirth, and there will always be unpredictable developments, bad outcomes, and loss. Perversely, attempts on the part of a provider to minimize risk by controlling or restricting who is in the room can short-circuit an effective strategy for maximizing the chance of a good outcome—namely continuous labor support.

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237. *See id.* at 774 ("One study found that the likelihood of labor ending in a cesarean was 15% higher when the hospital's obstetrics practice had been sued a certain number of times in the previous four years." (citations omitted)).

238. *See* Jamie R. Abrams, *Distorted and Diminished Tort Claims for Women*, 34 CARDOZO L. REV. 1955, 1983 (2013) ("[T]he dominance of fetal harm infiltrates the obstetric standard of care by prioritizing fetal patients over the birthing woman and by diminishing the birthing woman as a patient and a putative plaintiff.").

239. *See* GOER & ROMANO, *supra* note 183, at 2–3

> The medical management model defines success as a live mother and a live baby in reasonably good physical condition at the time the patient is discharged from the provider's care. Care is therefore structured to prevent and, when prevention fails, manage serious problems that may result in death or serious short-term morbidity.

240. *See* Sawicki, *supra* note 234 ("[H]ealth care providers dismiss birthing mothers' informed requests for minimal intervention during labor and delivery in an effort to reduce the risk of fetal harm, even when that risk is minimal.").

2. Power Dynamics Surrounding Childbirth

During a hospital birth, the physician is in control along with the hospital and other providers such as nurses, who exercise discretion in conveying information to the physician as labor progresses and in delivering care within their scope of practice. Generally, the physician controls how the patient learns information relevant to making an informed decision about treatment. This role is at the basis of the fiduciary relationship between physician and patient, where the physician bears particular responsibility to the patient stemming from the physician's superior knowledge, expertise, and ability to exercise power over the patient.[241] Patient experiences of coercion and other forms of mistreatment indicate that some providers are not exercising that power appropriately,[242] and that gender, race, and other aspects of a patient's identity may exacerbate the power differential in the physician-patient relationship.[243] Doulas can provide accountability in such instances by bearing witness, even if they are not empowered to challenge a care provider's recommendation directly. Though doula support as an intervention does not address the underlying tension created by these power dynamics, in some situations the presence of a doula can provide a counterbalance to help address this inequality.[244]

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241. *See* Andrew Grubb, *The Doctor as Fiduciary*, 47 CURRENT LEGAL PROBS., no. 2, 1994, at 311, 313–14.

242. *See* Elizabeth Kukura, *Obstetric Violence Through a Fiduciary Lens*, *in* CHILDBIRTH, VULNERABILITY AND LAW: EXPLORING ISSUES OF VIOLENCE AND CONTROL 204, 205 (Camilla Pickles & Jonathan Herring eds., 2020).

243. *See* Vedam et al., *supra* note 80, at 2 ("Women of colour . . . and those who face social, economic, or health challenges reported higher rates of mistreatment [during pregnancy and childbirth].").

244. Doula involvement may also complicate power dynamics in the delivery room. For example, racially-concordant or culturally-congruent care is associated with reduced experience of racial bias by patients and greater patient satisfaction, and the desire for culturally-congruent care influences some racially minoritized patients in their choice of doula. *See, e.g.*, Mojtaba Vaismoradi et al., *Looking Through Racism in the Nurse-Patient Relationship from the Lens of Culturally Congruent Care: A Scoping Review*, 78 J. ADVANCED NURSING 2665, 2673 (2022); Kristin Gourlay, *Data Show Community-Based Doulas Improve Outcomes for Black Mothers*, BLUECROSS BLUESHIELD (Apr. 11, 2022), https://perma.cc/77V7-Q39X ("[D]oulas hired by community-based organizations can do more to improve health outcomes and reduce racial

Beyond the individual provider, there are institutional factors shaping childbirth experiences and the degree to which the autonomy and dignity of the birthing person are respected throughout the childbirth process. Power flows vertically in the hospital setting, from nurse to resident to attending physician and all the way to department heads, risk managers, and hospital administrators, who set hospital-wide policies and may weigh in during complicated cases. Important decisions about how care is provided may rest with the individual physician, a hospital administrator, or both—with implications for the patient's ability to give meaningful informed consent, the role of coercion in shaping decision-making, the likelihood of avoidable medical complications due to unnecessary intervention, and the degree of patient satisfaction with the care provided.[245] Such decisions by the hospital or provider include whether vaginal birth after cesarean is available at a particular hospital or with a particular obstetrics practice,[246] how far past forty weeks the provider will wait for spontaneous labor to begin before encouraging or insisting on induction,[247] the availability of

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health disparities than programs that don't use workers with intimate knowledge of the communities they serve."); *Birth Doulas*, CHICAGO BIRTHWORKS COLLECTIVE, https://perma.cc/XV48-HMVZ ("We specialize in connecting melanated mamas with birth doulas who understand your experiences and provide culturally congruent care."). But the gender, race, and other identity characteristics of an individual doula may also heighten power dynamics in the delivery room, especially in situations where the pregnant person and doula share one or more marginalized identities that differ from the identities of physicians and nurses assigned to the patient.

245. In an extreme example, litigation underway in New York forced Staten Island University Hospital to disclose a policy permitting physicians to "perform[] procedures and surgeries without a pregnant woman's consent if they can't persuade her to give permission and several doctors agree that the treatment carries a 'reasonable possibility of significant benefit' for her fetus 'that outweigh[s] the possible risks to the woman,'" which enables a physician to override a competent patient's decision to decline a cesarean without the physician needing to seek a court order. Molly Redden, *New York Hospital's Secret Policy Led to Woman Being Given C-Section Against Her Will*, THE GUARDIAN (Oct. 5, 2017), https://perma.cc/HAQ7-VZQD. This policy was not disclosed to patients, one of whom was subjected to a forced cesarean over her explicit objection. *Id*.

246. *See* Elizabeth Kukura, *Choice in Birth: Preserving Access to VBAC*, 114 PA. ST. L. REV. 955, 957–59 (2010).

247. *See* DECLERCQ ET AL., *supra* note 70, at xi (finding that 41% of mothers reported that their physicians tried to induce their labor, with 18% being induced due to "a provider's concern that the woman was overdue").

birthing tubs and other supports for physiologic birth,[248] the number of companions a birthing person is allowed to have,[249] and how many hours of active labor before a "failure to progress" diagnosis leads to cesarean.[250] Liability, public relations, and economics may drive institutional or provider decision-making instead of adherence to evidence-based medicine or the best interests of the individual patient. The amount of power the birthing person has relative to other actors in the delivery room or in the institution may be lessened further by the birthing person's race, class, insurance status, age, disability, or other identity or status. This kind of decision-making does not promote good health outcomes or result in positive birth experiences.

3. Medical Paternalism as a Feature of Perinatal Care

Not all providers share the goal of empowering the birthing person to make decisions regarding their own care. For some providers, a more traditional model of physician-driven clinical decision-making is preferable, whether because it is more efficient, obviating the need for extended discussion and answering questions about the proposed course of treatment, or simply because it enables the physician to control the course of treatment, which may provide professional satisfaction and align well with the physician's self-identity as a healer or savior.[251] Gendered aspects of reproductive health care, and

248. *See* Mary Ann Stark et al., *Importance of the Birth Environment to Support Physiologic Birth*, 45 J. OBSTETRIC, GYNECOLOGIC & NEONATAL NURSING 285, 285 (2016).

249. *See supra* notes 1–7 and accompanying text.

250. *See* Rebecca Dekker et al., *Friedman's Curve and Failure to Progress: A Leading Cause of Unplanned Cesareans*, EVIDENCE BASED BIRTH (Aug. 28, 2018), https://perma.cc/6UW7-ATUL (last updated May 25, 2022) ("[T]his diagnosis can be very subjective—different providers have different ideas of how long is 'too long', and some providers are more patient (or impatient!) than others.").

251. *See* Julie Gantz, Note, *State Statutory Preclusion of Wrongful Birth Relief: A Troubling Re-Writing of a Woman's Right to Choose and the Doctor-Patient Relationship*, 4 VA. J. SOC. POL'Y & L. 795, 799 (1997) ("Traditionally, physicians viewed and treated patients like children. The doctor made decisions 'in the best interests of the patient' without revealing information about treatment, side-effects, or alternatives. . . . [W]ithholding

childbirth in particular, make it fertile territory for the exercise of medical paternalism over patients.[252] Traditional gender dynamics that vested in men caretaking responsibilities for women and children and shaped power dynamics between (mostly) male physicians and their female patients[253] may lead some physicians to act in what they consider to be the best interests of the pregnant person and the baby without including the patient in that decision-making.[254]

Medical paternalism is present in many aspects of prenatal and perinatal care. For example, scholar Jill Wieber Lens has analyzed the lack of counseling regarding risk of and methods to prevent stillbirth as a reflection of medical paternalism, finding that physicians choose not to counsel patients about this risk during prenatal appointments in order to spare them the possible fear and anxiety physicians assume will result.[255] Others have noted forms of paternalism such as a provider saying, "We'll just go ahead and get you started on a Pitocin drip"—which means the provider is initiating a medical induction of labor without counseling about the risks and benefits of such intervention and without obtaining the patient's informed consent.[256]

An extreme version of this paternalism emerges in the concept of maternal-fetal conflict, the term used to describe situations where a patient disagrees with the physician's

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information and even outright deception were regular practices rationalized as appropriate methods for protecting patients from bad news.").

252. *See* Kukura, *Obstetric Violence*, *supra* note 81, at 778.

253. *See* Gantz, *supra* note 251, at 798 (discussing the "formerly entrenched paradigm of the all-knowing, all-powerful, father-figure doctor").

254. *See id.* at 821 ("State bans on wrongful birth actions . . .invalidate the importance and effect of women's reproductive decision-making and paternalistically allow a doctor to substitute his judgment for that of his patient . . . .").

255. Jill Wieber Lens, *Medical Paternalism, Stillbirth, & Blindsided Mothers*, 106 IOWA L. REV. 665, 667–68 (2020).

256. *See* Kukura, *Obstetric Violence*, *supra* note 81, at 734; *see also* Holly Goldberg, *Informed Decision Making in Maternity Care*, 18 J. PERINATAL EDUC. 32, 36 (2009) ("Contradictory to patients' reports of wanting information and decision-making authority, empirical evidence from various health specialties indicates that the majority of physicians underestimate patient preferences to participate in health-care decisions.").

recommended course of treatment and declines to consent.[257] Medical language frames this in terms of a maternal-fetal conflict, as if the pregnant person is acting in opposition to the fetus rather than making the decision they deem best for fetal wellbeing and for their own health under the circumstances.[258] Medical paternalism underlies the idea of "maternal-fetal conflict" as a way to describe such situations; as Michelle Oberman has observed, in situations where the physician and patient disagree about an intervention, it is more appropriate to refer to "maternal-doctor conflicts" as they involve "doctors' seemingly well-motivated efforts to promote maternal or fetal well-being by imposing their perception of appropriate medical care on their pregnant patients."[259] In such circumstances, resistance to the physician's recommendation leads the physician to "invest[] the fetus with interests and rights that directly coincide with [their] own personal treatment preferences."[260]

4. Departures from Evidence-Based Care

Despite a robust body of research on obstetric and low-intervention midwifery practices, a significant proportion of perinatal care departs from the available evidence about the most effective practices in favor of adherence to older customs or practices that favor physician interests.[261] This includes the routine use of electronic fetal monitoring despite research showing it has not delivered the anticipated improvements in fetal health outcomes,[262] with implications for patient mobility

257. *See* E.J. Stein & C.W.G. Redman, *Maternal-Fetal Conflict: A Definition*, 58 MEDICO-LEGAL J. 230, 230–31 (1990).

258. *See id.* at 230.

259. Oberman, *supra* note 86, at 453–54.

260. *Id.* at 454; *see also* Kukura, *Obstetric Violence*, *supra* note 81, at 777–78.

261. *See* SAKALA & CORRY, *supra* note 46, at 8 ("[C]omparing current maternity care practice and performance in the United States to lessons from the best available research and to performance benchmarks reveals large gaps. . . . [M]any practices that are disproved or appropriate for mothers and babies only in limited circumstances are in wide use."); Kukura, *Contested Care*, *supra* note 71, at 270–77.

262. *See* Sartwelle, *supra* note 183, at 1 ("[T]oday EFM remains obstetrics' *deus ex machine* despite overwhelming and damning scientific evidence that

and progression of labor;[263] arbitrary time limits on duration of active labor and pushing phase;[264] routine use of the lithotomy position during pushing instead of vertical or hands-and-knees positions that aid in achieving optimal fetal positioning;[265] overuse of induction and cesarean surgery;[266] and various other common clinical practices in perinatal care.[267]

The routine use of non-evidence-based practices has a negative impact on the standard of care, as it is difficult to hold a physician responsible for failing to provide evidence-based medicine when many colleagues, against whom the provider will be judged, also fail to practice evidence-based obstetrics.[268] Furthermore, researchers have observed that the medicalization of childbirth has skewed research results on best practices for healthy birth outcomes by asking the wrong questions, such as comparing the efficacy of two different interventions, rather than measuring efficacy of one intervention against non-intervention.[269] This suggests that

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EFM theory is nothing more than myth and wishful thinking . . . ." (citations omitted)).

263. *See* Dekker, *supra* note 250 ("Practices that restrict mobility—such as being hooked up to continuous electronic fetal monitoring or IV fluids—should not be used unless medically necessary.").

264. *See* Kukura, *Obstetric Violence*, *supra* note 81, at 730 ("Existing guidelines are based on averages—meaning some women with healthy deliveries take more or less time than the average—and these expectations have changed over time, shortening in response to hospital and provider desires to make birth more efficient.").

265. *See* SAKALA & CORRY, *supra* note 46, at 54 ("Initial evidence also suggests that a hands-and-knees position helps reduce pain among women with 'posterior' babies.").

266. *See* Kukura, *Contested Care*, *supra* note 71, at 267–72.

267. *See id.* at 272–74, 276–77 (discussing approaches to pain relief and positioning during delivery that do not reflect the best available evidence).

268. *See* Kukura, *Obstetric Violence*, *supra* note 81, at 783 ("To determine whether the physician breached a duty in a malpractice case, the court compares the physician's conduct to the applicable standard of care, which refers to 'that degree of skill and learning ordinarily possessed and exercised, under similar circumstances, by the members of his profession in good standing . . . .'"); Carter L. Williams, Note, *Evidence-Based Medicine in the Law Beyond Clinical Practice Guidelines: What Effect Will EBM Have on the Standard of Care?*, 61 WASH. & LEE L. REV. 479, 498–512 (2004).

269. GOER & ROMANO, *supra* note 183, at 17 ("The medical management model . . . acts as a cultural blinder, limiting what research questions get asked, what comparisons are made, what outcomes are considered important, how results are interpreted, and what implications are seen"); *see also* Kukura,

even adherence to existing evidence on when and when not to intervene falls short of what would be necessary to ensure optimal physiologic birth with the highest likelihood of good maternal and infant outcomes.[270] It also underscores the benefit of being accompanied by a doula who can help the birthing person identify relevant questions to ask about why a particular approach is being employed or recommended and whether alternatives exist.

5. Erosion of Ethics of Care

One might look at hospital and physician efforts to restrict and minimize the role of doulas in perinatal care and be confused about why so many primary providers of obstetrical care are resistant to a cost-effective, evidence-based approach to improving health outcomes. In this way, we can think of restrictions on doula support as irrational, self-defeating, and counterproductive. An observer might also be confused by the fact that whether birth support by a trained professional should be available regardless of ability to pay seems to be an open question in the American healthcare system rather than a foregone conclusion. These debates reflect the degree to which "care" is often missing from the institutions and individuals from whom patients seek assistance in managing their health.

Philosophers have developed a theory of care ethics in response to the principlism and duty ethics that have historically dominated the field of medicine.[271] Care has been described as being "with the other and for them," which requires the carer to expand their own views in order to meet the care needs of another, a process that introduces unfamiliarity, can feel vulnerable, and may implicate the carer's own

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Contested Care, *supra* note 71, at 293–94 ("Where particular philosophies, cultural attitudes, or clinical practices predominate, their very ubiquity may render their impact on the scientific research process invisible.").

270. *See* GOER & ROMANO, *supra* note 183, at 17 ("[T]he ubiquity of the medical management model has instituted a set of iatrogenic norms, a range of normal values for normal biological processes that come from measuring the effects of medical intervention but are believed to be inherent parameters of the physiologic process.").

271. *See generally* Giovanni Maio, *Fundamentals of an Ethics of Care*, *in* CARE IN HEALTHCARE: REFLECTIONS ON THEORY AND PRACTICE 51 (Franziska Krause & Joachim Boldt eds., 2018).

self-identity.[272] Scholars have observed that the caring qualities that enable physicians to be receptive to patients' feelings and values are not adequately cultivated in medical education, or perhaps are trained out of them as medical students and residents are assimilated into the culture of medicine.[273] Care ethics also contemplates the role of gender in shaping the physician-patient relationship and the extent to which caring is part of that relationship or is absent from the parties' interactions during labor and delivery.[274]

The lack of "care" in health care also reflects the degree to which health care is about business and profit for private entities, highlighting certain conditions unique to the American healthcare system.[275] Hospital administrators and providers of medical services more generally must keep their eye on the financial bottom line and face economic pressures that are often in tension with providing optimal care.[276] Desire for efficiency in labor and delivery wards has led to technological innovations such as remote monitoring of multiple patients by a single nurse at a nurses' station elsewhere on the floor, reducing the amount of time a nurse can spend with individual patients attending to their physical and emotional needs.[277] Efficiency concerns can also result in pressure to end a long labor with a cesarean in

272. *Id.* at 52 (discussing the philosopher Paul Ricoeur's exploration of the ethics of care).

273. William T. Branch, Jr., *The Ethics of Caring and Medical Education*, 75 ACAD. MED. 127, 128 (2000) (noting that "doctors lose this intense receptivity to patients later in their training," which "suggests that medical education fails to maintain and may even suppress students' orientation toward caring").

274. *See* CAROL GILLIGAN, IN A DIFFERENT VOICE: PSYCHOLOGICAL THEORY AND WOMEN'S DEVELOPMENT 24–63 (1993) (developing a theory of women's understanding of relationships as an interconnected web versus men's understanding of a hierarchical structure).

275. *See, e.g.*, ELISABETH ROSENTHAL, AN AMERICAN SICKNESS: HOW HEALTHCARE BECAME BIG BUSINESS AND HOW YOU CAN TAKE IT BACK 223–29 (2017).

276. *Id.*

277. *See* Kellie M. Griggs & Elizabeth K. Woodward, *Implementation of the Fetal Monitor Safety Nurse Role: Lessons Learned*, 44 AM. J. MATERNAL/CHILD NURSING 269, 270 (2019) ("In the ideal nurse staffing model, the labor nurse would be assigned to one patient and be able to focus solely on continuous assessment, care, and support of one mother and her fetus; however, this is not routine in all hospitals." (citation omitted)).

order to make the bed available for another patient—and to collect another fee.[278] The presence of a doula may interfere with clinical decision-making that prioritizes underlying economic concerns over evidence-based, patient-centered care.

Finally, resistance to doula support—and the lack of "care" inherent in policies and practices that limit such support—may also reflect resistance within mainstream medicine to acknowledging and incorporating women's expertise regarding their own bodies.[279] Expanded use of this type of intervention—continuous, unconditional, nonjudgmental support during labor and delivery—looks a bit more like birth in the colonial days, where the birthing woman "called her women together" and, with their support, welcomed new life into the world. Mainstream perinatal care as currently conceived is not constructed to function this way.

V. THE FUTURE OF DOULA REGULATION

With strong research to support the benefits of continuous labor support by doulas, it is clear that the doula model presents a relatively untapped resource for addressing some of the failings of the current perinatal care system in the United States. Doulas help reduce labor duration and improve health outcomes, they aid in making the emotional and psychological transition to parenthood, they serve as a connector between pregnant people and other support or services they need, they help birthing people find their voices and advocate for themselves with their healthcare providers, and they help hold healthcare providers accountable by bearing witness in the delivery room as an informed and knowledgeable observer.[280] Hospital credentialing requirements undermine the potential to

278. *See* Kukura, *Obstetric Violence*, *supra* note 81, at 769.

279. *See, e.g.*, Maya Salam, *For Serena Williams, Childbirth Was a Harrowing Ordeal. She's Not Alone.*, N.Y. TIMES (Jan. 11, 2018), https://perma.cc/D7S3-HJPE ("[Tennis star Serena Williams] alerted a nurse to what she felt was happening in her body . . . , but the nurse suggested that pain medication had perhaps left Ms. Williams confused . . . ."); *see also* Gabrielle Jackson, *Why Don't Doctors Trust Women? Because They Don't Know Much About Us*, GUARDIAN (Sept. 1, 2019), https://perma.cc/MXH2-64CC (discussing gender bias in medical research, medical knowledge, and medical treatment that minimizes and ignores women's illnesses).

280. *See supra* Part II.

realize the benefits of doula support on a more systemic basis and thus should be opposed and withdrawn on the basis that they represent a poor regulatory fit. Hospitals and individual providers should instead recognize doula support for the value it brings to the delivery room and encourage efforts to integrate it throughout mainstream perinatal care. Part V.A will detail the argument against hospital credentialing of doulas, and Part V.B will identify several approaches to changing public and private norms related to birth support, highlighting where work that is already underway needs additional investment or prioritization.

A. *Doula Credentialing as a Regulatory Mismatch*

Hospitals should not use the COVID-19 pandemic as a justification for introducing new doula credentialing requirements, and hospitals with such requirements already in place should eliminate their policies. Doula credentialing is not an appropriate way to address legitimate hospital and provider concerns about patient safety and infection control. Credentialing requirements constitute a poor regulatory fit for at least three reasons: (i) violation of patient autonomy; (ii) the association of doula support with positive health outcomes; and (iii) the benefits to providers of improved communication, patient satisfaction, and healthy births.

First, credentialing requirements restrict the pregnant person's choice of support person in a manner that violates patient autonomy. The need for formal certification, the cost of credentialing fees, the need for criminal background checks, and even the need to navigate hospital bureaucracy impose burdens on prospective applicants that will dissuade some doulas from participating and act as absolute bars for others.[281] This limits the pool of doulas permitted to attend births in a particular hospital and may impede pregnant people from selecting a doula with a shared background, culture, or language or someone who shares the pregnant person's values and communication style—all of which are relevant to the meaningful provision of birth support and may put birthing people who belong to racial and ethnic minorities, are religious minorities, or are

281. *See supra* Part IV.C.2.

immigrants at particular disadvantage. Some pregnant people seek a doula who will be a strong advocate in the event of provider coercion or mistreatment, and the hospital's ability to exclude doulas through cancellation of their credentials may discourage doulas from helping patients advocate for themselves out of fear of losing access to all clients giving birth at that hospital, which interferes with individual patients' ability to protect and exercise their rights in childbirth through their choice in doula. Concerns about patient safety and infection control do not outweigh the violation of autonomy presented by credentialing requirements, especially given that family or friends may attend birth without facing the requirements a doula must satisfy to obtain a credential. The ethical requirement to respect patient autonomy alone should dictate against adopting doula credentialing schemes.

Second, as discussed previously, continuous, nonjudgmental support by a non-medical provider is associated with a variety of positive health benefits, including shorter labors, fewer interventions, and fewer cesarean surgeries.[282] The United States is in the midst of a maternal health crisis, with more women dying each year from pregnancy- and childbirth-related causes than anywhere else in the developed world and Black women (and other women of color) dying at disproportionate rates.[283] Doulas represent a cost-effective, successful intervention to improve perinatal health outcomes.[284] Limiting doula support through outright exclusion, barriers to entry, or restrictions on scope of practice for credentialed doulas all impede realization of the health benefits that flow from doula support, especially for Black women and other birthing people of color who have greater risk of suffering maternal mortality or morbidity, or poor infant outcomes. A hospital's desire to exercise control over who is present in the delivery room does not outweigh the clear health benefits of doula support.

Finally, hospitals should forego credentialing schemes for doulas because unimpeded access to doula support serves the interests of both institutional and individual providers in

282. *See supra* Part II.A.

283. *See supra* notes 74–79 and accompanying text; Kukura, *Better Birth*, *supra* note 39, at 281–88.

284. *See supra* Part II.B.

avoiding liability, ensuring patient satisfaction, and maintaining a strong clinical record. As discussed previously, one important factor in predicting whether a patient will sue a physician for negligence is whether the patient is satisfied with the way the physician communicated during the course of treatment.[285] Doulas are trained to help their clients seek the information they need, ask questions of their providers, and be prepared to provide consent that is truly informed.[286] When patients understand enough about a proposed treatment to feel prepared to consent, they are less likely to fault providers for poor communication if something subsequently goes wrong.[287] Thus, contrary to the belief on the part of some obstetricians that doulas increase the risk of malpractice exposure, research on patient decision-making suggests that doula involvement can improve patients' perception of and experience with physician communication.[288]

In addition, reputational concerns suggest that it would benefit providers for hospitals to eliminate credentialing schemes or to decline to implement them in the first place. As discussed above, doula support is associated with a reduction in the number of women reporting negative or traumatic birth experiences.[289] To the extent that individual physicians care about attracting new (or repeat) patients to their practice, it serves their interests to welcome doula participation in births they attend—even for physicians who do not believe themselves to have contributed to the negative or traumatic experience of a patient. Relatedly, the improved health benefits associated with doula support are reflected in the statistics of the obstetric practice—and the hospital more generally—so provider and

285. *See supra* note 220 and accompanying text.

286. *See* BEY ET AL., *supra* note 8, at 12 (noting that doulas are expected to learn "to use advocacy tools and methods of communication to ensure that the pregnant person is centered in a position of agency in relation to the hospital staff and other care providers attending the birth").

287. *See ACOG Committee Opinion*, *supra* note 221, at e36 (recognizing that shared decision making "has been shown to improve patient knowledge around their care, allow for better understanding of risk, and improve patient outcomes and satisfaction").

288. *See, e.g*, Gruber et al., *supra* note 101, at 50 (reporting "more satisfying experiences during labor, birth, and postpartum" for birthing women when doulas are present to provide support).

289. *See supra* notes 107–109 and accompanying text.

hospital reputational concerns strongly suggest supporting and promoting access to doulas, rather than limiting or excluding doulas from the hospital through credentialing requirements.[290] Given the hostility and skepticism that some physicians have regarding doulas, it may be necessary to offer specific education to help providers see how promoting doula support serves their interests as well as their patients' interests.[291]

B. *Investing in Doulas*

In contrast to the doula credentialing schemes currently being considered and implemented by hospitals, there are several policies and advocacy strategies that should be adopted in order to expand and promote the doula model of care.

First, states should prioritize inclusion of doulas in their Medicaid programs with fair eligibility criteria, straightforward administrative requirements, and reimbursement at a living wage.[292] This will raise the profile of doulas, enlisting state programs in the work of educating Medicaid beneficiaries about the availability of doulas and the benefits they provide. It will also dramatically increase access to doulas, especially for low-income people and people of color, who disproportionately rely on Medicaid for their health insurance and who are also at disproportionate risk of experiencing mistreatment and other adverse health outcomes as a result of pregnancy and childbirth.[293] Inclusion of doulas in Medicaid programs will

290. In particular, hospitals are judged by their cesarean rates, which suggests that they would want to capture the benefit of the reduction in cesareans associated with doula support. *See, e.g.*, LEAPFROG GROUP, HEALTHY MOMS, HEALTHY BABIES: HOSPITAL PERFORMANCE ON LEAPFROG'S MATERNITY CARE STANDARDS BASED ON RESULTS OF THE 2020 LEAPFROG HOSPITAL SURVEY 2 (2021), https://perma.cc/F3B4-VVXG (PDF) (describing an organization's use of the cesarean birth rate among "the population of women least likely to need a C-section" as "a standardized way to compare hospital performance").

291. *See* Laura B. Attanasio et al., *Community Perspectives on the Creation of a Hospital-Based Doula Program*, 5 HEALTH EQUITY 545, 551 (2021).

292. Policymakers should heed the warnings of community-based doulas about the pitfalls of inadequate reimbursement. *See, e.g.*, BEY ET AL., *supra* note 8, at 22 (noting that programs operating with fees comparable to New York's proposed Medicaid reimbursement rates "have been unsustainable").

293. *See* DECLERCQ ET AL., *supra* note 70, at xi (reporting that 27% of women who were familiar with doula care but did not have a doula at their birth indicated they would like to have had doula support); *see also* Wilson, *supra* note 24, at 233–234 (arguing that Medicaid coverage of doulas will help

likely lead to more widespread private insurance coverage as well, as insurers become more familiar with doula services—and their cost-effectiveness—and as increased awareness of the benefits of doula support in the population more broadly encourages people to demand doula coverage through employer-based plans and in the marketplace for individual private plans. Along with Medicaid coverage, expanded private insurance coverage of doula services is a critical step toward expanding access to birth support and ensuring patients at all income levels can benefit from doula care.[294]

Second, states and private foundations should invest in the development of a community doula workforce to expand access to birth support in communities of color particularly hard hit by the maternal and infant health crisis and at a disproportionate risk of mistreatment during childbirth.[295] For example, in Philadelphia, the Perinatal Community Health Worker Program (formerly the North Philadelphia Community Doula and Breastfeeding Program) at Maternity Care Coalition started training community doulas in 2013, supported by a foundation grant.[296] The program, which provides doulas a stipend for births they attend but is free to childbearing families, has received over 1,700 requests for doula support and matched those pregnant people with doulas from 2013 to 2020.[297] In 2019, the program received funding from the Lenfest North Philadelphia Workforce Initiative at Temple University, which enabled it to expand its training from twenty to twenty-seven sessions and to offer participants $50 for each

address the paucity of labor and delivery units in Washington, D.C.'s poorest wards).

294. *See generally* Nan Strauss et al., *Overdue: Medicaid and Private Insurance Coverage of Doula Care to Strengthen Maternal and Infant Health*, 25 J. PERINATAL EDUC. 145 (2016).

295. *See* Ashlei Spivey & Elizabeth Barajas-Roman, *Prioritize Doulas in Black and Brown Communities*, HEALTH AFF. FOREFRONT (June 2, 2022), https://perma.cc/WXN9-PDGA (arguing for expansion of the doula workforce to "make meaningful change for Black and Brown people as they give birth").

296. *Partner Spotlight: Maternity Care Coalition*, TEMPLE UNIV. LENFEST N. PHILA. WORKFORCE INITIATIVE (June 17, 2020), https://perma.cc/Z8B5-U2UL (June 17, 2020) [hereinafter *MCC Partner Spotlight*] (noting the program's success in "increasing the birth worker workforce in communities that are experiencing the highest disparities, inequities, the highest rates of maternal mortality, and the lowest breastfeeding rates").

297. *See* Black, *supra* note 145.

session they attended.[298] The program is designed not only to expand the community doula workforce, making free doula services available to communities of color, but also to prepare participants to pursue careers as perinatal community health workers that will enable them to earn a living wage while serving their communities.[299] Cultivating growth of this workforce requires long-term investment, but the individual and community benefits of doula support and the potential for expanded opportunities to secure stable employment suggest this investment will pay off.

Third, doulas and other birth advocates should engage in advocacy directed at hospital administrators, insurers, and clinicians to correct misperceptions about liability risk and the health benefits of doula care.[300] Researchers have noted the need for interprofessional education on "clarification of roles, common nomenclature, quality standards, and increased collaboration with a shared understanding and respect for the contributions that each individual healthcare team member offers to the care of the laboring patient and family."[301] This process should begin early in medical education and training, with obstetrics residency programs and nursing programs developing formal opportunities to learn about the distinct role of birth doulas, the research on the benefits of continuous labor support by actors in a nonclinical role, and the scope of practice of doulas.[302] In addition, training for physicians and nurses should include sufficient opportunity to attend doula-involved births in order for providers to develop the relevant communication skills and to prepare to operate in clinical environments where doulas are present.[303] The need for education also extends to hospital administrators, so that leaders who make policy can appreciate how the benefits of doula support accrue to healthcare providers and institutions, not simply to individual patients. Furthermore, advocates have had some limited success persuading insurance companies to cover doula services as a

298. *Id.*
299. *See MCC Partner Spotlight*, *supra* note 296.
300. *See* Lucas & Wright, *supra* note 222, at 38.
301. *Id.* at 37.
302. I am grateful to Professor Barry Furrow for this observation.
303. *See* Lucas & Wright, *supra* note 222, at 38.

Medicaid benefit, a model that should be expanded to all insurers.[304]

Finally, doulas should prioritize organizing themselves and their clients as consumers of hospital services to advocate for systemic changes in the relationship between hospitals and doulas. Political mobilization is necessary to change the underlying cultural conditions related to the need for and availability of birth support. This type of organizing has been ongoing,[305] and restrictions on birth support during COVID-19 have inspired more concerted and widespread doula organizing,[306] but more work is needed. Because credentialing poses a risk to the autonomy of doulas and their clients, raising concerns about conflicts of interest created by such arrangements, collective action is necessary to resist hospitals' attempts to marginalize doulas. Though not all doulas agree on the desirability of formal hospital agreements[307]—or about the role of politics in doulaing more generally—there is an opening for the political education and mobilization of more doulas to promote the model of care.[308]

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304. *See, e.g.*, *A Glimpse of Pettaway Pursuit Foundation*, PETTAWAY PURSUIT FOUND., https://perma.cc/5VM3-6QD4.

305. *See, e.g.*, *Doulas Coming Together to Advocate for Birthing Families in Michigan*, MICHIGAN DOULA COAL., https://perma.cc/BA3C-YRJY (describing a statewide coalition of doulas to discuss "supporting one another in the field and in the profession, challenges and barriers in birth work, improving maternal and infant health outcomes, pursuit of compensation through private and public insurance, and more"); *Doulas For Birth Options*, https://perma.cc/XZ4N-NAPD.

306. *See* Rodeghier, *supra* note 10; Van Syckle & Caron, *Women Will Not Be Forced to Be Alone When They Are Giving Birth*, *supra* note 10; *see also* Chapman, *supra* note 12 (discussing strategies for provision of virtual doula services during COVID-19 pandemic).

307. For a discussion of the for-profit ProDoula organization and its support for credentialing as a way to enhance the status of doulas, see *supra* Part IV.C.

308. *See Meet Nickie Tilsner | Co Executive Director of Cornerstone Birthwork Trainings, Registered Nurse, Birthworker, Harm Reductionist*, SHOUTOUT HTX (Feb. 23, 2022) ("Birthwork is political. Through this work, we destigmatize reproductive experiences, choices and outcomes. We interrupt injustice in healthcare spaces. We reconnect with wisdom about self, community and planet that has been lost and stolen throughout the generations. Together, we are reclaiming human rights starting at the beginning: Birth.").

As doulas become better understood, more accessible, and more prominent in childbirth in the United States, calls for state licensing of birth doulas are likely to become louder, as is typical when new service providers in the healing arts or health-adjacent fields enter the professional landscape.[309] Licensure advocates will cite the need to ensure appropriate training and to protect pregnant people from "bad" doulas as justifications for imposing a standardized regulatory framework.[310] It is certainly possible that doulas themselves will ultimately decide that state licensure (or its equivalent) is beneficial in terms of expanding access through public and private insurance coverage or in terms of ensuring the accountability of doulas to their clients and to fellow doulas engaged in a shared project of providing nonclinical support to birthing people. But pursuing licensure would be premature at this time, as doulas across the United States are currently exploring within their professional communities how to organize themselves (in for-profit businesses, non-profit organizations, or collective models) and with what training; how to be both accessible and financially sustainable (employing a private fee-for-service model, pursuing public and private insurance coverage, or relying on individual and institutional fundraising to support the work); and how to understand their role as advocates while serving as doulas, where the focus is on providing individualized support in whatever form the client needs but doing so in the context of a perinatal care system infected with racial bias, paternalism, and other forms of discrimination.[311]

Rather than rush to equate doulas to other birth workers who serve in clinical roles—such as physicians, nurses, and midwives—society must first recognize what doulas are (and are not). This requires understanding the underlying conditions in the healthcare system that have spurred the growth of and

309. *See* NAT'L CONF. OF STATE LEGISLATURES, THE EVOLVING STATE OF OCCUPATIONAL LICENSING: RESEARCH, STATE POLICIES, AND TRENDS 6–13 (2d ed. 2019).

310. *See, e.g.*, *id.* at 6 ("[O]ccupational licensing helps consumers when they cannot easily asses the professional's skills and when the costs related to poor quality are especially high, as is the case with emergency health care providers.").

311. *See supra* Parts III.A–B.

indeed necessitate birth doulas within mainstream perinatal care.[312] To the extent that doulas fill a desperate need for more care within the healthcare system—care that is individualized, racially-concordant and culturally-congruent, and not subject to the same legal and economic pressures that shape clinical care—licensure may not ultimately serve the goals of the doula model of care and its potential to transform how we care for childbearing people.[313]

Current advocacy to reshape public and private policies regarding doula support will bolster the ongoing work among doulas and sympathetic obstetric personnel to create opportunities for interprofessional exchange among physicians, nurses, and doulas to increase familiarity and build mutual respect.[314] These efforts are essential to ensure that, amidst an ongoing maternal health crisis, no birthing person will be denied the support they need to have a healthy and respectful birth experience.

CONCLUSION

Arundhati Roy has written about the COVID-19 pandemic as a portal, inviting readers to imagine a new world and to prepare to create that new world.[315] Given the challenges of facilitating safe and healthy births during a global pandemic—amidst an ongoing maternal health crisis—the portal is certainly open for imagining new ways of caring for pregnant and birthing people in a post-pandemic world. The last two years have introduced hard lessons about risk management and balancing health precautions with evidence-based perinatal

312. *See supra* Part I.B.

313. *See supra* Part III.C.

314. *See supra* notes 300–304 and accompanying text.

315. Arundhati Roy, *The Pandemic is a Portal*, FIN. TIMES (Apr. 3, 2020), https://perma.cc/9QLH-FQWN

> Historically, pandemics have forced humans to break with the past and imagine their world anew. This one is no different. It is a portal, a gateway between one world and the next. We can choose to walk through it, dragging . . . our data banks and dead ideas . . . [o]r we can walk through lightly, with little luggage, ready to imagine another world. And ready to fight for it.

I am grateful to Indra Lusero for introducing me to the concept of the pandemic as a portal.

care,[316] and the pandemic has exacerbated existing problems with access to care and the mistreatment of birthing people.[317] Some hospitals are seizing the opportunity provided by temporary doula restrictions implemented during the pandemic to institute permanent credentialing programs to regulate who provides doula support to patients within the hospital, inspired by misguided notions that asserting control over doulas will serve important goals related to the delivery of healthcare services and maximizing patient outcomes.[318] Advocates and consumers should oppose these efforts and instead use the portal provided by COVID-19 to pursue a world where all birthing people have the support they need during pregnancy and childbirth, regardless of their location, status, or financial resources.

Expanding access to doulas respects patient autonomy, promotes better perinatal health outcomes, and serves the financial and reputational interests of individual providers and hospitals.[319] It is also essential to changing cultural norms around medicalized childbirth and improving birth experiences in the United States. Peer support by a doula reconfigures power dynamics in the delivery room, which is necessary in order to achieve a healthcare system that recognizes the birthing person as performing valuable and dignified reproductive labor, rather than as an object upon which procedures or interventions are performed in an attempt to manage or expedite delivery of a baby.[320] Shifting delivery room power dynamics improves the quality of the patient experience and will contribute to efforts to reframe childbirth from something risky and fearful to

316. *See* Gan-Or, *supra* note 3, at 5–7.

317. *See* Kukura, *Seeking Safety*, *supra* note 1, at 295 ("In general, research suggests that people of color, low-income people, and young people disproportionately encounter coercion and other forms of mistreatment by health care providers during childbirth; restrictions on doula support due to COVID-19 concerns put these patients at greater risk of . . . being subjected to unwanted intervention.").

318. *See supra* notes 13–14 and accompanying text.

319. *See supra* Part II.

320. *See* DAVIS-FLOYD, *supra* note 26, at 286 ("Women in American society have been deprived, not only of social 'equality' but also of their cosmic significance as birth-givers, transformed even in the transformation of giving birth into mere machines to be manipulated and repaired.").

something normal and healthy—with benefits for everyone involved in the care of birthing people and their families.[321]

321. *See* Helen M. Haines et al., *The Influence of Women's Fear, Attitudes and Beliefs of Childbirth on Mode and Experience of Birth*, BMC PREGNANCY & CHILDBIRTH, June 24, 2012, at 1, 12 ("Working towards a positive experience of birth is one of the most crucial goals the health team must set. Most especially midwives and doctors must discuss any fears the woman may have."); *see also* Kathrin Stoll & Wendy Hall, *Vicarious Birth Experiences and Childbirth Fear: Does It Matter How Young Canadian Women Learn About Birth?*, 22 J. PERINATAL EDUC. 226, 230 (2013).