CHAPTER IV

RESULTS: ADVOCACY AND EMPOWERMENT

Advocacy emerged as a major component of the doula's work during labor. Both mother and doula participants acknowledged that during the prenatal period, doulas often prepared parents for the situations they might face during their hospital birth. This involved coaching how to advocate for their wishes if it became necessary. The major findings about the functions of advocacy include under what conditions informational support became advocacy; empowerment as an underlying philosophy; why doulas felt advocacy was necessary. Other main findings include descriptions of the processes of effective and ineffective advocacy; communication processes; and the prenatal preparation of parents.

Informational Support and Advocacy

Informational support and advocacy emerged as related but separate processes of doula care. According to the doula participants, informational support was offered to all mothers and labor partners. It had an emotional support function of alleviating anxiety, as well as a communication function of assisting parents and careproviders to dialogue with one another. It also led to parental awareness that there were additional options other than the recommended course of action by their health care provider. Further analysis revealed that advocacy was a process instigated by parents, which began when they decided they wanted additional choices than what their medical care provider was offering them. The doula's role then expanded into supporting the parents in advocating for themselves, at the level of involvement in decision making that the parents wished to have. It was possible for doulas to only provide informational support to parents at their birth but do little to no advocacy. However, the initial step in the

advocacy process began with the informational support provided by the doula. In this way, these two functions of doula care were separate but also overlapped.

Once parents indicated that they wished to negotiate or explore different options in their health care decision making, the function of informational support changed. It now had a specific purpose, and was given in service of assisting parents to advocate for themselves. From the doula's perspective, giving informational support indicated respect for the mother's autonomy and viewed the mother and her labor partner as an empowered decision-making unit. However, the parents actively determined whether or not to empower themselves. They chose their own preferred level of involvement with their medical care provider in making decisions. The doula followed their lead and this dictated her informational support and advocacy behaviors.

According to both mother and doula participants, mothers and their partners chose their level of involvement in decision-making at two critical points. The first came prenatally and was revealed by their choice of care provider. This was a critical decision as it dictated the type of care they expected to receive at the birth as well as what choices they expected to make. Different care providers ascribe to different philosophies of childbirth, with differing levels of technology use. Some practitioners prefer to manage labor with many interventions, whereas others have a preference for allowing labor to unfold organically. The parent's level of responsibility for their health care was also indicated by their decisions about prenatal tests and refusing or agreeing to induction of labor. The second time parents empowered themselves was during labor. At this time they took a more active or a less active role than indicated prenatally. In other words, mothers and fathers may have behaved differently than the doula expected from their prenatal meetings, plans, and decisions.

Empowerment

In examining the information revealed by doula and mother participants, empowerment developed as a critical and significant theme that influenced every aspect of advocacy. Some doulas and mothers used the word "empowerment", for others it was implied by their descriptions or actions recalled in their narratives. The definition for empowerment that emerged was "the act of claiming one's own influence over a situation and taking responsibility for its outcome." This definition fit every instance that has been identified as relating to empowerment.

Participants described empowerment by an expectant mother as an active process, not a single action or attitude. Prenatally it began with the choice of where to give birth, such as home, hospital, or birth center; and choice of the care provider, such as an obstetrician, osteopath, family practitioner, certified nurse midwife, or certified professional midwife. Sometimes, as parents became more focused on what they wanted for their birth, they realized their current care provider was less likely to offer them the options they wanted, or had a philosophy differing from theirs. This was seen by participants as a major decision-making point for most parents and an indicator of the level of action they were willing to take to get the kind of birth they wished to have. Parents who felt more empowered or who believed in a shared decision-making model might have switched to a medical attendant who could provide it. Doulas described that some parents, even though they might wish to change, remained with a care provider who had a medical management style. Other parents who might like to switch to a less interventionist doctor were restricted from doing so by a medical condition or health insurance restrictions. Often these parents hired a doula in the hopes that she would be able to help them get what they wanted. Allison explained what many doulas heard from their clients:

> "We knew we made really good decisions." Because she had changed care providers. She was sort of on that road anyway but through courses of conversations with me she

> decided to change care providers. She was with a physician practice that had a midwife; she thought that was good enough. She changed to a midwife at a different hospital. And she's like, "Thank God we chose that. I'm so glad you said it." I said, "Well, I could have said it until I was blue in the face, but you're the ones that did it."

Allison exemplified the attitude that it was the parents who had the power to influence things, not the doula. She went on to state that ideally, the doula would "help this woman to find her voice". Empowerment in this way was an encouraging process. Angela gave this example:

> "So the mom looked at me, 'What do you think?' I said, 'Well, its not what I think its what you think, but why don't we take a minute and talk about it.' So the midwife left the room and we discussed it, and I basically told them that it was ultimately up to them but this is not something that you wanted."

Many of the doula participants, and most of the mother participants, viewed empowerment as part of the process of becoming a parent. Advocacy was rooted in the belief of empowerment: that women, not their partners or caregivers, know what is best for them. For some parents, pregnancy was part of the process of individuation. Taking responsibility for another human being required maturity and taking responsibility for one's choices. A path to maturity was taking the responsibility for decision making, which was thrust upon a woman in the process of becoming a mother. No matter what her age, the responsibility for another human being was different from any other responsibility. Eve spoke about this at length in her interview. She explained a situation where a mother underwent a test for cervical cancer during her pregnancy.

> "She told me that she didn't really want to do the PAP smear but she went ahead and did it anyway. And I wrote her back and said, "You know this is the start where you're going to have to do things that you think you're right about." So I e-mailed her that, thinking that was a better way to do it, because I think if I would have done it in person, I would have been trying to scold her or something. Because she's 29 years old, she's an educated woman, she really felt bad about it, and even if they did—thank God they didn't find anything—but even if they did find bad cancer cells, you can't do anything now!
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> So I wrote this all out and sent it to her and I said, 'You have to start being in charge. You're in charge now.' So that's kind of what things I said, like I try to focus on more

> now than telling women, 'You know, you're going to have kids. You're going to have to defend them for the rest of their lives."

According to the participants, an effective doula intuitively understood this and desired to nurture this sense of autonomy and personal responsibility by empowering the mother to make her own decisions – both prenatally and in labor. The more a mother educated herself about her labor options, the easier the task for her doula. She just needed to remind a mother of her potential choices. For Bonnie, because of her strong belief in empowering parents, advocacy was a very subtle thing. "But I think that just letting them, the mother and her significant other, know that you are there for them. I think that's what is important." She felt that her presence was enough so that parents could choose to speak up on their own behalf most of the time. For other doulas, like Mia, empowerment was something that was subtly encouraged by the doula. "I'm not there to interface with the doctors. I'm there to talk to you and to help you figure out what it is you want and remind you of that." Other doulas, like Lani, were more outspoken about the concept of client responsibility and its importance in empowerment.

> "I think that's a big part of it, is that women are not taking responsibility for their own experiences. They're turning themselves over, and they don't realize, Doctor so-and-so says, 'When you're five centimeters and you come to the hospital we're going to break your water and blah, blah, blah.' She says, 'She doesn't want her water broken.' And he says, 'But that's what we do in our practice.' And she stays in the practice. I mean, then she complains when her water gets broken. Well, but you didn't take responsibility for your birth. If that's the case, you need to change and take responsibility for your birth."

Colleen was in a situation with a client who stated she wanted few interventions. The mother discovered that her doctor and medical practice were likely to want to intervene, but decided to stay with the practice. In her story, Colleen was anguished about what she saw as a negative experience for this mother and an unnecessary cesarean. Yet, she was also aware that unless the mother empowered herself, there was little a doula could do to help the situation change.

> "Basically what happened was that she was very healthy, she had a perfect pregnancy, and yet she was more than a week overdue and he wanted to induce. And we talked about it and nothing would dissuade him, and she felt that she had to do what he said. So she went in to the hospital and—she went in the night before—and she told me that he was talking about rupturing her membranes in the morning. And I said, 'Listen, you've got to talk to him about this. You really have to say to him, 'I don't want you to do that.' Because, you know, depending on the state of your cervix, you just may not be ready to go into labor yet. And once your membranes are ruptured, you're on the clock.'
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> Well, guess what happened? By the time I got to the hospital—and it was early morning—she was ruptured. I was just sick about it because she didn't go into labor. And a few hours later they started Pitocin, and a few hours, I'm talking from 8:00 in the morning until 4:00 in the afternoon, her doctor called a cesarean, because she wasn't making any progress…If she had gone into labor on her own, I think most likely she would have had a healthy birth, with no need for intervention. I really think so. I mean there weren't any signs to indicate otherwise…I think that the whole thing related to her lack of self-confidence probably. That she chose a doctor because she wanted someone else in control. And even though she said she wanted to do it without interventions, she went to a medical doctor and she went to a medical, you know. She was willing to go along with what he was suggesting, even though I was advising her perhaps to try to wait awhile and to definitely hold off on being ruptured. But nevertheless, I wasn't there and she told them to go ahead. Even if I had been there, she probably would have gone for it."

In her story, Colleen recognized that the mother was the principal decision maker and she supported her to the level that the mother wished her to do so. Once the critical choice has been made to begin the induction, the mother had set events in motion and accepted the option offered by her physician. The critical point for the doula was that the mother had made her choice and made it actively based on knowledge and information. Even if it was different than what the mother stated she wanted prenatally, the mother still made her choice. This point was acknowledged as significant by all of the doulas practicing effective advocacy. As Teresa acknowledged, some women are just not ready to take on the responsibility for their own birth experience.

> "We don't know where we're coming from yet when we're giving birth the first time especially, but there are some women who just do not have that inner strength or self esteem or whatever you would call it to demand things that they rightfully deserve. Or to even know enough that these things are even possible or attainable or within their grasp if

> they only asked. Or just even refused certain things. Just don't know. Just not there yet and may never be there."

While empowerment was important for the doula, it was something she offered to her clients, not something she required them to do. It seems a contradiction in terms for a doula like Teresa to acknowledge that women can be complicit in their own disempowerment but also be accepting of that complicity. Yet that acceptance of a woman exactly where she is lies at the heart of being a doula. Empowering oneself was an opportunity made available through the health care decision making of pregnancy and labor. But it was not a requirement. Lani elaborated on her point of view, one shared by almost all doulas in the study:

> "As long as she has made her decisions along the way, if she is the one who truly makes those decisions, then I think it's okay. I still think she would have been better off [refusing the intervention], but at least she's made her own decision, and things haven't been done to her. When things are done to them, forget it…There is no empowerment if things are done to them. If things are done with them, as them being the decision makers, I have much less of a problem with it."

This was not to say that doulas did not have personal feelings when mothers made choices that the doula did not feel were in the mother's best interest. But those feelings were carefully masked. Lani used a catchphrase from their profession that was repeated to me by many doulas, "You cannot have an agenda. You can't. It's not your birth. I mean it's not your birth, it's not your birth, it's not your birth, [sometimes I say it] like a million times over and over again." For several reasons, the doulas more easily reconciled the mothers making different choices than their doula had. First, it may have been because she knew the mother had been informed. Secondly, she recognized that personal empowerment is a lifelong growth process and pregnancy and labor are just two additional opportunities for that process to occur. In Teresa's words, her undercurrent of strong emotion can be felt.

> "There are some doctors in our area who will not talk about birth with their clients until she's eight months pregnant. So that's their way of literally not having to deal with their

> questions for eight months worth of prenatal visits. And there are women who are like, 'Okay.' [I'll ask] 'What is your doctor...?' 'Well, I don't know, we can't talk about that until next month or two and half months from now.' 'What?' You know, its like, 'That's okay with you, huh?' Women let it happen or they don't like it and they still don't change. Or they get to eight months and the doctor tells them all this stuff that they don't want, that they don't agree with, they don't change anyhow. They say they want whatever, but they keep seeking out the path that's least likely to achieve that. Kind of like the women whose husband beats her but she keeps going back. Horrible analogy, but to me very similar."

However, this anger was not directed at the mother, but at the fact that she must fight a system that was not set up to allow her to have a great birth. Almost all doulas in this study acknowledged these feelings. This anger was a part of grief over the loss of what some doulas see as a transcendent experience. As Lani put it, "I hate it. I hate it. Because I know what birth can be like, and I know what I believe it's supposed to be like. [tearfully] Oh, there's so many of them, it's really sad. I hate that. That's the hardest thing for me."

The personal process of empowerment during labor was seen by these doulas as an opportunity for mothers and their partners to grow into parenting. Evaluating information and making conscious decisions was valued as part of the maturing process of adulthood. Doulas value this function of the labor and birth process and saw their role as supporting parent's own advocacy as an almost sacred function. Acknowledging one's own needs and speaking up for oneself was seen as a part of the rite of passage of childbirth. Empowerment was the interior force involved in why advocacy was seen as necessary by doulas. In the next section, we will examine the exterior forces perceived by doulas that make standing up for oneself necessary.

Why Doulas Felt Advocacy Was Necessary

When families decided to have their babies in a hospital, the control of the situation was seen by doulas and mothers as having shifted from the parents to the physicians and the facility. Their rules and protocols predominated over a patient's wishes. As Jo Ann, an experienced

doula from New Orleans, stated, "You can't expect to go into a hospital setting and think that you have a lot of choices, that you control that setting. You can't. You have to look at that and you have to work within their controls." Jo Ann was talking about the doula as well as the parents when she discussed control, and she acknowledged that the doula's role was to work within the hospital system. In other words, a patient gave up control over certain decisions, but might work within that system to get some things she wanted if she knew how. Mothers also had little control over who attended them in labor. Physicians have call schedules and share call with as many as twelve other physicians. There was no control over the nursing staff. Thalia, a doula from Long Island, New York, pointed out that a mother can not ask, "What nurse on staff is going to help me the most? I'm going to ask only for her.' There's reality here." Because mothers usually could not choose who attended them in labor, they were seen as needing to work harder to communicate their needs and advocate to get those needs met.

Another reason that doulas felt advocacy was necessary was that the hospitals were designed to meet the needs of large numbers of patients at one time. Their priorities were seen as physiological safety and management of labor along predictable lines, not emotional security and individualizing treatment. Jo Ann spoke for many of the doulas in this study when she made this statement about members of the birth team: "You may also be the only one there who's [primarily] concerned about that mom's emotional safety and security." It was not that staff were seen as uncaring, but that their medical roles and responsibilities restricted them from placing a mother's emotional wellbeing as a priority. Lani, a doula in New Jersey, expressed a great deal of frustration when she attended births that did not recognize the specialness of this experience in a family's life. She said, "I see what goes on in the hospitals, and the women are robbed of their birth experiences on a regular basis. And I can't stand it. They're just robbed of

their experiences. And I feel like the doctors just want to get in and out. I mean with exceptions obviously."

A third reason that doulas felt that advocacy skills were a necessity was that labor was often unpredictable. Circumstances changed and mothers and their partners needed to adjust. Thalia put it this way, "The times that talking comes up is when there's been some kind of shift in the plan or in the expectation. And then there's discussion and brainstorming about, well, how do we deal with this? How do we want this to go, or this intervention?" Doulas assisted parents with brainstorming by providing information or soliciting options from careproviders.

Doulas and mothers described that the need for a decision was often presented as being immediate. Parents perceived that there was a rush to make a decision because of a safety concern. However, usually the staff was in a rush to make a decision only because they had other tasks to accomplish. As Lani explained, "The way that advocacy is, is that we ask first of all if it's an emergency; a true emergency, there's no advocating, they just do what they're going to do. But ninety-nine percent of the time it's not a true emergency." Because the doula understood this behavioral distinction, she helped the parents to understand they could take some time.

Lastly, it was perceived by participants that in the hospital system a patient often needed to be persistent in order to get their needs met. This could be challenging for mothers in active labor as well as those unfamiliar with the hospital system. This was another reason advocacy was seen as necessary – the doula could help the parents persevere or find less confrontational ways of accomplishing their goal. Thalia illustrated this with her story:

> "Why don't you ask him to have a telemetry unit [portable EFM], we could put it around your belly and we could walk a little bit, if they're so insistent upon you lying here with that thing around your stomach. I heard that they have one here, but you have to speak up for it.' The first nurse said, 'No. I don't know where it is,' and she was very

> disagreeable. I said, 'You know, she's going off in ten minutes. Why not ask another one.' Sure enough, the next one found it for her. But she [mother] wouldn't have done it had I not pushed her to do it."

Needing to be persistent, understanding the behavior of medical staff, working within the limitations of the hospital system, having an unpredictable labor, not being able to choose one's medical attendants, not having control, and desiring to create a special birth experience that honors one as a person are all reasons that doulas perceived the need for advocacy. These are all exterior influences on a mother's birth that, unless she was prepared to deal with them, may have derailed her ability to cope well and have a satisfying experience.

The Doula Style of Advocacy

The doula's definition of advocacy rested on the ideas of empowerment and assisting the mother and her birth partner to speak up for her needs. As Teresa, a doula from Detroit, said:

> "I explained the limitations of my role in that regard because they [medical staff] don't really want to hear from the doula what she wants. They want to hear it from her [the mother] and in my opinion they should. Even if they would, did, are capable of listening to me and treating me as a medical equal in the setting that we're in, I still don't think it should be coming from me. It's not me speaking for her."

Delia, who usually worked with a wealthy clientele in Sarasota, Florida, elaborated:

> "I'm encouraging her to ask lots of questions, and it has to come from her. And always kind of, they know when they set up a meeting with me that their doctor's probably not really pro-doula. So that they'll have to voice a lot of their questions and wants and desires themselves, but I would be right there behind them to back them and support them in whatever the decision is. If there's something that they want and I know that they're probably not gonna get it, I think I would probably prepare them. But it's probably going to be a little bit of a fight or a tug and stretching for that doctor. But bottom line is that they've employed this doctor, and technically he's their employee, if they look at it they're paying him for a service and he's working for them. So they have the right to request those wishes. If it's done the right way they usually get what they need."

In her statement, Delia's value of empowerment of the couple was transparent. So was her idea of appropriate advocacy: that the parents needed to voice their questions, wants and desires. She supported them in asking and also previewed if there might be a possible negative

response. She also framed the situation in that the parents had a right to ask for what they wanted because they were consumers and paying for a service. The most intriguing part of her statement was that "if it's done the right way they usually get what they need". Very clearly there was a right way of making a request and a wrong way. (The most effective methods of conducting advocacy will be discussed in a later section.) For over ten years, Suzy, a doula in Clearwater, Florida, had attended the births of mothers who were indigent. However, her perspective was quite similar to Delia and Teresa.

> "I think that they [nurses and doctors] see that a good doula doesn't tell a woman what to do and what not to do. And granted I think that from their point of view, they don't want a doula saying, 'No, you don't need that', when a doctor says a woman does. Or being very verbal to them rather than speaking to the mom. You know, 'No, she doesn't want that'. [gestures as if nurse replies] 'Excuse me I don't work for you, I work for the mom'. I can understand that, and I think that's part of it. And I think that they don't want doulas that are giving medical advice. I think it's very important to tell a woman, 'I've seen other women do this, check with your care provider and see if it's okay with them'. I think it's a good way to present things.
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> But oftentimes the mom will say, 'Oh, is this something that I have to do now? Can I wait?', and then make the decision. Maybe make the decision to do it or make the decision not to. But, but I've been there oftentimes when, not just me, I feel like if a doula hadn't been present, the mom would not know what was taking place. And I'm not sure, whether it takes place or not is the important function of that. I don't think it's my goal to stop things that mom doesn't want to stop. But at least to let them know."

Suzy introduced the idea that "other women have done this, check with your care provider" as a way to support mothers in empowering themselves. She used strategies to build their confidence in voicing their desires. However, she noted a conflict in herself and lets us know how she had dealt with it: "Oftentimes, if a doula hadn't been present, moms would not know what was taking place." This means either the doula explained what was happening or prompted someone to explain. These incidences were usually doing an amniotomy during a vaginal exam, cutting an episiotomy, or even giving pitocin when a mother had an epidural. If the mother did not know what was taking place, she obviously had not been consulted as part of

the decision. Suzy's conflict came from her values of maternal empowerment and bodily integrity: that the mother ought to have been consulted as part of the decision about what was done to her body and her baby. She recognized this when she made the statement, "I'm not sure whether it takes place or not is the important function of that." It was not whether the procedure happened that matters, but whether the mother had been a part of the decision. Suzy's other conflict was that she may recognize what was happening as a decision making point, but this mother did not. "I don't think its my goal to stop things that mom doesn't want to stop." She recognized the mother's autonomy to make a decision even if that choice was to be passive.

Other doulas were very clear that they did not address medical staff at all when it came to advocacy. Doris was a newer doula in a small city in eastern Ontario, Canada. She said, "What I am now able to do with ease is, when there's an explanation from a doctor or a decision, I'm able to turn to the couple and say, "Do you have any questions, or are you okay with that?" Mia, from Long Island, New York, told her clients,

> "I do not advocate for you during the birth. Your husband can, and I may remind you that this may be something you didn't want. Or we'll talk about, 'How about if Mom and Dad have a half an hour to sort it out?' Or I'll leave the room and let them talk about something. But I'm non-confrontational. Once I'm in the birth setting, I'm there really as a support person. I'm not there to interact with the medical staff."

For these doulas, advocacy was not about interacting with medical staff or explaining what a mother wanted. It was about reminding mothers and birth partners that this was a discussable issue and a decision making point, and that it was their job to address it if they wished. Sophie, a doula from New York City, concurred:

> "Well, witnessing is probably my specialty. Because I don't do any advocating at all. If a woman is going through a procedure or a having something done which is clearly medically unindicated, clearly for convenience, clearly hospital insanity, I just witness it. I don't really know how to describe it. I'm just present, fully present for it. Hold her hand through it."

Mental Preparation for the Advocacy Role

Participants stated that effective advocacy required preparation by both the doula and the parents. The first step that doulas described was a growing awareness of the political nature of doula work and their position in the hospital power structure. Second, doulas prepared parents prenatally to advocate for themselves during labor and birth in the hospital. Third, doulas developed a specific communication skill set in order to increase their effectiveness. All of these were types of mental preparation that the doulas did before commencing labor support for a particular mother or family. In these next sections we will explore each of these processes, starting with the doula's preparation.

As doulas grew in experience, they developed an increasing awareness of the political atmosphere in which their clients were birthing. Almost all doulas shared stories of experiences where medical staff insisted on procedures their clients did not want, and times when nurses and doctors seemed to be motivated by a power struggle with the doula. As they grew in experience, doulas realized there were influences on healthcare that had nothing to do with what may be best for the mother or her baby. "Defensive medicine", where doctors make decisions based on reducing their liability risk, was commonly mentioned. So the first meaning of preparation was the development of a mindset that advocacy was needed for the patient's sake but that it took place within a power structure where the doula had no acknowledged position. Doulas in this study realized that even if advocacy communications were not intended to challenge the existing power structure, they could do so. Understanding this principle was an important part of being effective at a doula style of advocacy. Anytime a patient asked for individualized treatment options that were outside the norm, she was asking for a nurse, midwife or physician to exercise their power within that system on her behalf. Understanding how that system worked in their

community was important for doula success. Jo Ann, the doula from New Orleans, was quoted earlier as saying that "it's a political system…and you have to work within their controls." Here she explained at length about what was meant by playing a political game:

> "I mean you have to learn to play a nice little political game so that your mom is protected. You gotta keep protecting your mom because sometimes if you don't play a political game, she's not protected. You don't want to fight with the doctors. You don't want to have the caregiver looking at you like 'Who the heck are you? I will make sure that this woman will have a horrible birth because she thinks you are more important than I am.' We all have felt that. I mean I'm going to be real honest with you about all this stuff. We've all felt that. You want to just continually protect your mom and sometimes you stand back and don't say a word because that is how your mom is going to be protected. Sometimes you overstep those boundaries just a tiny bit and you suggest something to the doctor because the mom is in absolutely no position to say something to them."

Jo Ann's point of view was that all doulas were playing a game to help their mom get the best possible birth at a hospital. At times, some doulas chose to say nothing and blend into the background because that was the best way. At other times, doulas pushed a little because that helped their clients best. Doulas like Mia and Sophie, who said they do no advocating, had chosen this style because it worked best for their moms in the setting they worked in. Suzy and Lani, who attended births of single mothers without birth partners, do more active interaction with medical staff in those circumstances. So part of preparation for advocacy was considering the possible situations or conflicts one might encounter depending on the physician practice, hospital protocols, labor circumstance, and mother's wishes.

Another aspect of developing a mindset for advocacy was cultivating an attitude towards physicians. Jo Ann's contribution was an awareness of politics, but Mia stated that a doula needed to consider what attitude she brought to the hospital about doctors.

> "As far as the doctors that I've worked with, you know I kind of think it's like when you go to France. Some people go to France and find the French to be very arrogant. If you go to France, think of it as a beautiful country with a lot to offer and, you know, try your

> hardest to be at all accommodating, it's a terrific place to be. Doctors have a job to do. They're trained in a certain way. They're kind of overbearing in technology."

Understanding the physician's perspective and role was very important to effective advocacy. Their job was to diagnose a condition and prescribe treatment. Nurses provided that treatment as ordered. Diagnosis is a judgment call and evidence must be carefully considered before a diagnosis can be made. Therefore, physicians in particular specialties may diagnose and prescribe differently. They may also have contrasting perspectives on certain treatments, such as surgery. (i.e. A surgeon is more comfortable recommending surgical options as a solution.) Understanding the general philosophy of a physician and his or her practice, and developing empathy for that approach increased the effectiveness of doula advocacy.

A second part of mental preparation for advocacy for doulas in this study was considering the needs of the individual client. If a client wanted a natural birth, for example, what did that mean? Sonia, a doula from Manhattan, explained. "Why do they want the natural birth? I think that why—different people want it for very different reasons, and being able to blend in with, for them, what piece of this was really important to them." Discerning why different mothers might want the same thing set them apart from one another. It was essential in offering emotional support and assisted with cultivating support from the nurses and other birth team members. Tierney, from suburban New Jersey, continued this thought.

> "I kind of go in with, I try, with a very blank slate. And I just try to align myself with where she's at and what her goals are. It's not my birth. And so I think I very easily kind of get into that place of picking up on what they want, and helping her get what she wants. And, you know, it's maybe different than what I want, but I kind of leave all that stuff at the door."

Tierney spoke of aligning herself with the client's goals – they became her goals. But she also recognized that even after twenty-five years, letting go of her own agenda was an active process. She left what she might want "at the door". Lani and Tierney, who worked together,

seemed to struggle with this more than other doulas in this study, even though they had attended hundreds of births. However their struggle was ongoing between valuing natural, noninterventive childbirth and empowerment. Almost all doulas recognized having that struggle at one time or another. Tierney continued:

> "I mean sometimes I – that's not to say that I don't get upset when there are situations where you want more for your client than they want for themselves, which is that frustrating piece of doula work because you kind of know the other side. But I find it pretty easy to get into that and to read other people and what they, what they need. And know when to step in and when not to."

Several times doulas mentioned that they wanted more for their clients - more fulfillment, more choices, a more peaceful atmosphere. Their clients seemed satisfied with what they were receiving. This was the "frustrating part of doula work", when a doula knows it can be better because she's seen it, but that it was not her place to champion it. Understanding the potential for this scenario was a part of preparing for a birth, as was letting go of one's own wants and desires. Lastly, doulas needed to prepare for the possibility that the mother's goals and desires may change during labor. Teresa explained.

> "I think there are some people who can still knock you for a loop. You think you know them or you think you're clear about what they've asked of you, what they're hoping to accomplish at the birth. You're trying to protect their birth plan in terms of honor what she has said her wishes for her birth. If she could this is what she'd like to do. And then you get there and things are disappearing and she doesn't seem to mind."

Doulas prepared for a specific role for each client. What a woman wanted from her doula varied from woman to woman. But so can what a woman thought she wanted and what she actually wanted during labor. The circumstances of the labor may have influenced this somewhat. Several doulas recalled times when they realized they had prepared to work with someone in a particular way, and the mother acted differently and expressed different needs than she thought she would during pregnancy. So preparation for advocacy involved readiness to

interact in a specific role with the added realization that one's role may be very different than expected.

Advocacy for doulas involved several different kinds of mental preparation and all involved shifts in awareness: awareness of the political ramifications of the mother's birth plan in the hospital system; of the doula's attitude toward physicians; of the doula's own agenda and active management of disguising those preferences; and awareness that the client's stated preferences may change during labor. Preparation for advocacy was an exercise in clarity of one's expectations and realization that the unexpected was what was most likely to occur. However it would be wrong to assume that the doula's preparation takes place in vacuum. Rather it was tightly interconnected with the parent's prenatal preparation for labor advocacy, which has been taught in part by their doula. In the next section, parental preparation will be covered, followed by the communication processes involved in labor advocacy and a focus on interactions with medical care providers.

Prenatal Preparation of Parents

During prenatal visits, doulas described that they were establishing rapport as well as educating parents. From their first meeting with mothers, the interactions that doulas detailed revealed their empowerment philosophy. As Allison phrased it, she wants to help parents "trust their own gut". She wanted to "help them find where they are strong, no matter what". As Ashley said about one couple, "These parents were wonderfully informed, and the mother could just let go and know that the husband and I were going to take [care of her]." According to the doulas, when parents were informed and empowered, a mother could labor more freely. She had the knowledge that her birth partner and doula would support her in communicating her wishes and ensured she was included in the decision making of her labor.

For many doulas, empowerment was closely linked with trauma prevention. When events were anticipated with anxiety, there was a greater chance for negative memories and even traumatic experience if the event occurred. Dealing with fears proactively was emotionally supportive, but advocacy was the solution for dealing with the situation when it arose. Allison explained this perspective when she had a client who was scared of a second cesarean delivery.

> "Because I think if you go into something rather feeling like you're being crucified and having a baby-ectomy, that you know, you're still giving birth and that there's ways to ask for things that you want. Like I remember one woman lamenting that she didn't see the baby come out. And so you present them with the thought that, 'You can see the baby come out if you want.' Or not. And that there are ways to do that compassionately so you don't have to see your whole abdomen, you know, inside out."

Thus, advocacy during labor stemmed not just from what parents wanted, but also what they deeply needed. Prenatal visits were a time when doula, mother and birth partner established a connection and rapport. For parents it was a time of sharing with someone they were learning to trust. For doulas, it was discovering who this mother needed her to be, what kind of support would work best for her. As Tierney shared:

> "I would say most of our work is done prenatally. What I tell couples is, when I get into labor with you I don't want us to even have to talk. I want to know as much about what you want and what your expectation is and how I can help so we don't have to have that conversation in labor. I should know as much about what you want for your birth as you know about what you want for your birth."

Besides grasping what was essential to the parent's positive experience, doulas also saw themselves as educating them about the birth process and hospital procedures. They introduced the idea that hospitals may have different priorities than parents. Regina, from the Treasure Coast area of Florida, was very clear about her role.

> "My job beforehand, I believe, is to make sure they understand the processes of birth, understand the options that are available to them, understand what the protocols are at the hospital where they going so when they go in there, they aren't like, 'I didn't even know they did this.' I don't do it in a negative way, I do it as, 'You've got lots of options here.

> Let's take a look at your options.' If they have questions about it, they can ask me beforehand."

Prenatal visits were also seen by participants as a time to teach skills, not just for labor coping but how to make requests of nurses and physicians. Camille said, "I try to sort out as much of that ahead of time with people, if that's what seems to be what they want to have happen ahead of time, and really actually role-play a little bit with people." In this next excerpt, Colleen revealed her empowerment orientation towards advocacy, what she did to encourage it, strategies she taught parents, and finally how these actions helped to prevent negative memories or trauma experience.

> "But I always think, if there's some way for somebody at some point to do anything about this, then let's figure out what it is. And to me, that's by having people be aware that they need to discuss things with their doctor, and that they need to ask questions. And I give them handouts. Like, what if—like if an intervention is proposed, to ask the doctor, 'Is my baby or my wife in any danger? What happens if we wait an hour? What are our other options?' You know, those kinds of questions. So that even though they may end up going with it, at least they'll know why, and they've felt like they were part of the process. Rather than just saying, 'Okay, whatever you say, Doc.' And then later on, feeling bad because they didn't question it or try to change it in some way."

Feeling part of the process, that birth happened with you and not to you, was one of the essential elements in birth satisfaction and trauma prevention to which doulas overtly referred. One of the first strategies doulas taught parents was to ask for more time to make a decision. If the parents did not remember to ask, most doulas said they ask the parents directly if they want more time to discuss things. Doris used another tactic:

> "I would talk ahead of time with them about ways to slow it down if they—you know, unless it's an emergency—if they feel that it's moving too fast for them. Questions to ask. Saying, 'Do we have to do it now? Could we do it just as well in an hour, without risk to anybody?' Sometimes I tell them that I have, I'll do an eyebrow thing if it's a situation where they might want to ask for time. It doesn't happen that much."

Doris wiggled her eyebrow as a secret signal to let parents know they ought to discuss their options further. Sonia also used signals during labor to communicate with fathers.

> "I use signals a lot with dads. We really pre—we memorize a script about: This is exactly what's going to happen to you, from the very beginning to the very end. These are the points where I need you to do things in a normal birth, and if it gets tricky, these are my signals to you that I need you at this point to step in and say something. And if we're here, you're going to say, 'We need a minute alone.' If we're here, you need to ask, 'Well how long are you going to be until you come back?' Whatever it is, so that they really know. And I even have dads who will write it down on an index card in their pocket, because they get, 'But how am I going to know my lines?"

Sonia has created a predictable timeline for when interventions are usually suggested and appropriate responses. This flow chart was complex enough that fathers felt the need to write it down.

Besides introducing techniques for making requests and getting information, prenatal visits also explored the potential for conflict between mothers and their care providers. According to the doulas and the mothers in this study, some parents hired doulas because they were already knowledgeable about the differences in their birth philosophy and that of their medical careprovider. Other parents engaged a doula without this awareness. Doulas felt that the place to begin was to assist parents in discerning their own birth philosophy. Through this process, mothers and birth partners realized their care providers may have different priorities and beliefs. Camille shared how she has gently introduced this topic when parents have shared their birth plan. "Oh, you know, those are all good things, and here are some good things about this hospital, and here are some things that you might have a conflict with." Sometimes parents did not realize that hospitals or physician practices do not all offer the same options. Camille had also said, "Okay, that's great that you want that, and yet this is where you are, so let's talk about some ways to compromise or change." Sonia had the same challenge:

> "Knowing that if Mom's going to techo-techo hospital with techo-techo doc, what that means for you, and what you can promise this mom about this experience. And being comfortable saying, 'This is, we need to understand this is where we're going, and if you really want a natural birth, let's talk about that, because I need to share with you that this is, this is a place that's….' And so kind of feeling out who they are and what they want."

Participants perceived that one of the doula's responsibilities prenatally was to assist parents with assessing whether they had a good match between themselves, their care provider, and place of birth. Camille and Sonia had shared how they initiate this process, but it was usually ongoing. Not only did mothers need to carefully consider their core needs and desires and those of their partner, but they also needed to ask questions of their care provider. It was the mother's area of concern to decide where she would acquiesce to the doctor or midwife's style, and where she would not compromise. This might have taken several weeks or months for mothers to reach conclusions and make decisions. Delia shared her attitude during this time, "I would never jeopardize that trust that that patient has with their doctor while they're in the midst of a pregnancy." It is not about violating trust or casting doubt, but about empowerment. As Delia said, "Bottom line is that they've employed this doctor, and technically he's their employee, if they look at it they're paying him for a service and he's working for them. So they have the right to request those wishes." This point of view was shared by many doulas in this sample.

Viewing medical care as a service invited the perspective of choice and changing careproviders. Camille stated her perspective quite clearly, which was shared by many doulas. "If you feel like it's going to be a battle at your birthplace, then you probably shouldn't be giving birth there. You should probably find a new place and a new provider or whatever." The birthing bed was no place for a battle between patient and careprovider. Conflict interfered with labor progress and had the potential to create a very nasty situation for everyone involved. However because of insurance and HMO restrictions, parents cannot always change if they want their health care expenses paid by these businesses. In these situations, doulas advised mothers

of what they could and could not do to support them in the hospital and suggested areas of compromise. But some patients did change careproviders, as Lydia explained.

> "A lot of times moms will change practice mid-pregnancy. A lot of my clients do, probably about a third of my clients change. Because all of a sudden they realize that they're not getting their questions answered. And I'm saying, 'Well have you thought about this?' Or, 'Is there anything that…?' Or, 'What is your doctor saying about that?', whatever 'that' might be. They're like, 'Oh, well when I asked that question, he hurried me out of his office. I'm sorry, I've got to go and see the next patient.' So I would say, 'Well how did you feel about that when he didn't answer your question and he hurried you out of his office?' And she says, 'Well, I don't think he's going to listen to me when he's in labor.' 'Well, what do you want to do about that? Do you want to stay with him? Or do you want to find somebody else?' And you always have the right, even in labor, to change practices. Or even change hospitals. So it's your choice, you tell me what you want to do. But a lot of them do."

One of the more controversial areas of doula advocacy was whether doulas convinced clients to change physicians, or change from a physician to a midwife. To doula participants, mothers assessed their needs, discovered their physician or physician practice was not set up to meet those needs, and realized they had the power to change the situation. Doulas presented the idea that mothers had choices, even if the choice was to ignore insurance coverage and pay a Licensed Professional Midwife out of pocket for a home birth. If they chose to stay with the insurance-covered physician provider, that was an active choice - not a passive one. All doulas who commented on physician care mentioned assisting mothers to assess their careprovider match, and all had a changing careprovider story. However, changing careproviders was not a goal, but it was a possible outcome of the empowerment process.

During prenatal visits, this process was subtle and began by asking questions. "What is important to you?" "What do you fear?" "How do you feel about that?" Then the doula utilized that information to gently introduce strategies for reducing conflict and communicating requests and needs during labor. She strove to reduce fear and anxiety by giving parents concrete tools, and pointed out areas where they might not have realized they have power and influence. In this

next section we will look closely at the communication processes of advocacy during labor, and how prenatal preparation transferred to actual practice.

Communication Processes of Advocacy During Labor

The philosophical belief underlying advocacy was the empowerment of the obstetrical patient in a system that did not automatically grant them power. While it was true that mothers still retained the right to refuse any procedures, many doulas realized that exercising that power during labor could be stressful. With their advocacy skills, doulas worked to find a way for parents to ask for individualized care in a way that nurses and physicians would provide it. Jo Ann spoke earlier about playing "a political game so that your mom is protected". However Sonia saw the situation differently. Here she explained what she said to parents.

> "Also helping them understand that we don't want any friction at the hospital. They don't want any friction and I don't want any friction. They want this to be really low-key, but understanding that they're a lot of times asking for things that are not part of the normal routine, so understanding that's going to make people just a little nervous. You know in the same way you come to a hotel and you ask for some crazy thing to be in your room; it's going to make people go, "Oh, you know, that's a little odd." And start talking about you: "The funny lady who's staying on the fifth floor requested XYZ funny thing." It's just because it's out of the ordinary, and it's not to mean anything about who you are. So, because of all that, we're going to do things in such a way that's going to keep everybody happy. We never talk about the doctor when they're in the room—you know, we do all these things to keep it really low-key, so that it never becomes us against them, and that they're really prepared to ask for what they want, and have the reasons why they want it."

In Sonia's point of view, there was more compassion for the hospital staff. It was also a viewpoint that could be easily empathized with by parents. What they were asking for was not negative, just "out of the ordinary" and "it's not to mean anything about who you are". By providing reasons, requests of staff had a meaningful context. Sonia strove to frame the situation in a way so that it was not polarizing. That would be a situation where everyone lost, especially her clients. In most of the narratives in this section, there was an undercurrent of the awareness

of power. The physician, nurse or midwife had the power to grant wishes, and the doula had none. The patient had power to ask, but only by asking in a particular way was there a possibility of them being granted. Thus, these communication strategies were all designed with that awareness.

Allison said, "There's ways to ask for what you want." Every doula in this study concurred with that statement. Some recognized that they still did not feel skilled in the advocacy role because of their uncertain communication skills, or discomfort with the power structure in particular hospital settings. However many of the doulas were very savvy about their surroundings and the efforts it took to practice effective advocacy. Camille was very insightful.

> "This is not something that is going to work or be a skill that everybody has focused on, but I went and got certified when I was an attorney as a mediator. I think for me, those mediation skills when I'm kind of helping all sorts of people, whether it's a labor and delivery nurse who has had a really bad experience with a doula before, or in-laws or whatever it is, I think that certainly finding kind of nonjudgmental yet direct ways to say things, and just finding language. And that could be a really easily learned thing. Instead of saying, 'What you should do is,' or, 'What I think is,' you can say, 'Many people have found it helpful.' So I guess practicing a little bit and becoming so that it's easy for you to put the sentences together, to have some ways to suggest things to people in a way that makes it seem almost like it was their idea. I think that that's very, very helpful with certain doctors and nurses that kind of have their arms crossed in the corner."

What was important about Camille's strategy was "nonjudgmental yet direct ways to say things" and using language in a way "to suggest things to people in a way that makes it almost seem like it was their idea". At a different time in her interview, she shared a story about a time she supported a mother in labor who she barely knew and who had no other support person with her. In this story, we can hear her using these strategies.

> "And so she was being induced, and I can't even really recall why. She was kind of a clinic patient and they didn't really give her any information. And she wasn't allowed to get out of bed, even to go to the bathroom, and she was on a monitor. And it was just really, like all of these things that you hear about that they don't really do any more? Well, they do them there.

> We just got into a rhythm. We didn't, as I said, we didn't even really know each other, we'd spoken once on the phone or something. And it wasn't particularly long. She responded to Cervadil. She didn't even need to have Pitocin or whatever. And we figured out a way to help her be comfortable and got into kind of a pattern. And at a certain point the doctor came in and said, 'I don't like these decels [on the fetal monitor].'" I kind of thought it was getting pretty close and that it might be some head compressions. And the doctor was like, 'No, I checked her ten minutes ago and she was only whatever, so I'm going to put in this internal monitor.' And I said, 'Well actually, the only thing that works for her is rubbing her belly, I think I'm maybe knocking off—I think it's my fault—I'm knocking off the monitor or something. Can we replace it? Will you give us a couple more minutes?' Because she was really frightened at the prospect of that, and she didn't really want them to break her water because she was a little nervous about that.
>
> And so he said, 'Okay,' because he was kind of busy and sleepy anyway. And then a few minutes later, I asked him to come back in and check her because I thought she was voluntarily starting to push. And he said, 'It's not possible, but okay.' And indeed she was, and so he said, 'Oh, she's going to have the baby.' So he grabbed his scissors to cut an episiotomy and she had expressed that she was nervous about that—because we hadn't had a prenatal or anything, so we were just sort of talking throughout her labor. And I said, 'Oh, she's really hoping, she'd rather tear but hopefully not.' And he's like, 'I've never heard of such a thing. She's a first-time mom.' And he was like, 'Alright, whatever.' And he didn't. So she didn't tear and she had a beautiful baby. And she didn't know if she was going to breastfeed or not, but we just sort of put the baby there and the baby latched on really easily."

Because she was with the patient continuously, Camille was able to observe the progressing labor and surmised correctly that second stage was imminent. When Camille asked for more time on the external monitor, she was being gentle in her language with the physician, but also slightly manipulative. "I think it's my fault…can you give us a couple more minutes?" The physician could have insisted on placing the internal for the baby's safety. Yet he opted to observe, which bought Camille's client more time to labor without the intervention. Camille did not disagree openly with the doctor's opinion on the mother's progress nor on his desire to cut an episiotomy. Instead she appealed to him on the mother's behalf by using soft language "she's hoping". Camille did not demand anything for her client. Instead she used her knowledge of the system to help her wishes be met. What was unusual about this example was that it involved

direct advocacy by the doula because of the lack of a birth partner. In this situation, doulas would often speak for the mother. Let's look more closely at communication strategies doulas used when mothers had their husband or partner present. First, Jo Ann shared that she made simple statements about what she observed. She did this in the hopes that parents would then share their feelings or confusion with the careprovider. Her desire was to enhance their connection and communication with one another, which positively affected their experience.

> "I think I help them communicate better. I help them communicate with their partners better, I think I help them communicate with the hospital staff better…I can look at a mom and if she looks confused or she looks like she didn't understand or she looks unhappy, I can say to her, 'You look confused.' I say, 'This is what I see.'…I'm not going to say, 'You look like you need to do...'. I say, 'You look confused, you look unhappy, you look like you did not understand that question. Do you want to say anything else?"

Bonnie shared that sometimes she made statements to parents reminding them of what they wanted. "Sometimes I will do, 'Well don't forget, Fred, that you had mentioned to me that you wanted to cut the cord." It was then up to Fred to pick up on the cue and continue the conversation with the careprovider. Ashley shared that she often tried to let parents know that this was a good time to ask questions. "Sometimes directly, I try to get the husband to do it, in feeding him the information. But at times things happen too quickly or something and I'll have to ask a leading question to try to get the answer for them right then and there or something." Sonia, the doula who taught signals and scripts to her clients, shared how those strategies unfold at the birth.

> "Oh, I kick under the [laughs and gestures], a kick, a nudge, a glare, you know, raising eyebrows and looking at the clock if I want them to ask, 'When will you, how long do we need to, until what time does she need to be on the monitor?' You know, those kinds of questions. Or I'll say, 'Oh,'—you know, some kind of a nudge to Dad to get him to remember what he's supposed to. 'Now did you…you guys were talking something about that, weren't you?' [Laughs] 'Oh, yeah, that's right,' you know. 'Are you sure she wanted an IV? Wasn't, weren't you talking something about that IV?' 'Oh, that's right, we don't want an IV.' And getting Dad to really feel like he doesn't need to remember

> anything because I'm going to be there to help him, but at the same time having him understand that I, as a doula, am not legally allowed to speak for them. And it goes much easier if he can do it for Mom, if Mom can't do it."

Observational statements, leading questions, and gestures were all indirect techniques prompting parents to ask or share about their needs. Both Bonnie and Sonia said they reminded fathers about their prior wishes. What was significant about this was that these were statements made to the father, not reminders to ask. The difference was that in the statement Bonnie made to Fred earlier, Fred then chose whether or not to state what he wants. This was an empowering statement. A statement such as, "Remember to ask to cut the cord", disempowers Fred. It puts Fred in the position of feeling like he has to explain to the doula why he did or did not make his request known. It was a statement that mothers make to their children, not one an adult makes to a peer.

Bonnie gave another example of parents talking indirectly about what was desired rather than asking openly for it. In this situation, both the doula and the parents supported one another in framing it in a way that would be acceptable to the doctor.

> "She did not want her water broken; she wanted it to break when it wanted to. And it was getting pretty close to delivery and he [doctor] questioned whether he should break it, just to get things speeded up because she was getting tired. This couple was of Scottish descent. And so she was pushing but she was also one of the ladies that when she's pushing, during pushes she's with it, she's not somewhere else. There was a discussion about in Scottish folklore or in going back, that being born in the caul is a good luck thing. In some things it's a sign of second sight. And we were just talking about it from that perspective, this sort of cultural one. Rather than say, "Keep your hands off it." It was sort of putting an insight in. Now even whether that was their intent of doing it or they just didn't want it to happen, but it was also because he knew their culture, it was something that I was sort of using to encourage him to let it happen. And I think she was pretty close. The baby wasn't born totally in the caul, but it was very close."

Notice that Bonnie and the parents never came right out and tell the physician not to do the amniotomy. Instead they talked about the mystical properties of the current circumstances, which subtly encouraged the physician to refrain. The parents began this exchange and Bonnie

supported them in it, "using it to encourage him", an indirect form of advocacy. Another indirect form was nonverbal strategies which created a situation for parents to advocate for themselves. Lani shared:

> "[The doctor] just said, 'The baby needs to be born and you need to have Pitocin.' And she's like, 'I don't want Pitocin.' Now, the weird thing is that I was sitting down, she was lying down, and her husband is up to here on me. So he's a little guy, and this big doctor literally standing over her on the bed. And totally without, and I didn't realize this until later, but completely without—it was intuition—I just, there needed to be balance in the room. And I knew, like in my body I knew it, so I stood up. So then he and I were both standing, because I had been sitting next to her near the bed, and then the husband was off, you know, his little 5-foot-4 self sort of like just praying in the corner, with the doctor saying this. And I stood up, and it was weird, the whole energy changed in the room when I stood up. He didn't have as much power anymore. And not that I had power, but there was some kind of a balance all of a sudden."

In this example, Lani realized her intuitive action equalized the power in the room. By all of them standing up, they were communicating differently; the floor was shared by everyone. Once again, Lani did no direct advocacy herself, but she provided the set up for the father to begin a negotiation. At other times doulas started out with an indirect strategy but felt it was necessary to become direct. This was especially true with preventing an episiotomy (a surgical incision in the muscles surrounding the vagina). Many doulas mentioned this as a time for trying one strategy but sometimes needing to switch. In the descriptions from Lani and Sonia, their different styles can be compared.

> Lani: "I will say something like, 'She's stretching very beautifully, isn't she,' as he is grabbing for the scissors. Because I can't, that's one place where I will advocate on her behalf because I really, if they don't want to be cut—the doctors automatically cut—so I will say something then. 'You know, Jane did not want to have an episiotomy.'

> Sonia: "There are times where I have a doctor with episiotomy scissors in hand, feeling a spot, where I'll say to Mom, 'It looks like Doctor X is cutting an episiotomy. You didn't want one of those, right? Why don't you see if you can give a really, really strong push and let's get this baby out.' Because there's no choice at that moment, I don't have a way to go about—I have two seconds. And then I will sort of go, 'Uunh, screw the rules,' look out the window and I'll—I'll just say my two cents and just try to say them in as nice a way as possible, so that no one can get upset."

Once again, the doula made an observational statement and then a reminder to the mother. Next, Sonia offered a slightly manipulative strategy to avoid the episiotomy. If the baby started to crown, the physician can not get the scissors inside the vagina to make the incision. The doctor must also prepare to catch the baby, which can not be done with the scissors in his or her hand.

One of the other areas that doulas discussed extensively was the strategy of offering to leave the room so the parents could discuss their choices. They perceived that the fear that medical people have was that the parents would do what the doula told them to. They fear that the doula had influence over their choices because of her intimate connection with the laboring mother and her partner. Since nurses and doctors recommended procedures to patients, it often did not occur to them that doulas remain neutral. Nurses will often make this statement to laboring mothers, "If it was me, I would…" Because of this, doulas were aware that being alone with clients during a decision making time was a political issue. Camille made this clear that when she asked parents, "Would you like us all to leave the room so you guys can talk about this?' To telegraph to them [medical staff] that I'm not, as soon as they walk out of the room, saying [whispers], 'Under no circumstances…" Sophie made an even stronger statement. "I don't like mothers to say, 'Can you give us [doulas and parents] five minutes to talk about it and leave the room?' I do not like that, I hate it, because that means when I leave the room, they [the medical staff] are going to section her. So anything that is said, I want the doctor there or at least a nurse." For Sophie, there can be retaliation from medical staff if they perceived that the doula had too much influence over the mother. The ironic thing was that many parents are opinionated on their own and did not need the doula to tell them anything. If they did not know what to do,

the best strategy was to figure out what questions they still had and obtain answers from nurses and doctors. As Eve suggested,

> "I tell my client, 'If you're not sure of something, or you want to ask a question, you always can ask the nurse or the doctor," or whoever is there to tell you what you're supposed to do or what they think you're supposed to do. To, "Please leave so I can talk to my partner." Never talk about, "Telling my doula," because that's a good clue that there's [hand gesture]. They don't want to hear about 'talking to the doula!"

In this last scenario, Ashley shared a familiar story of advocacy support. However, there were two distinct differences. First, the careprovider was a midwife who voluntarily left the room for the parents to discuss their options. This occurred after the doula had made an empowering statement to the parents. Second, the doula viewed the midwife's motives as being supportive of the parents. The midwife was seen as offering the intervention for their benefit, not because she believed it was best.

> "We came in the mom was only at two centimeters, and the midwife had suggested that they use pitocin. So the mom looked at me, you know, 'What do you think?' I said, 'Well, its not what I think its what you think. But why don't we take a minute and talk about it.' So the midwife left the room, and we discussed it, and I basically told them that it was ultimately up to them but this is not something that you wanted. There's no reason really to do it right now. You know, they lived further away from the hospital than normal so I think the midwife was looking to save them a trip. I said maybe you should just go home and get some sleep and I'll go home. And that's what they decided to do, which worked out well because four hours later we were back at the hospital and everything went well. But you know, I think just taking the time alone for them to talk – even if they don't want me to be in the room…I'm always going to suggest that – so that they can decide what they want."

When a patient advocated for their wishes, doulas in this study recognized that what they were also doing was requesting a shared power dynamic between patient and caregiver. This worked best in environments that were more patient-centered. If staff were supportive of meeting individual patient needs, their requests were more likely to be received well. However, in environments that were not accommodating, or when nurses and doctors felt that patient requests were not important, doulas reported that advocacy may not have had positive outcomes.

The first two stories have to do with mothers who refused an IV insertion. The IV insertion can be annoying and painful, but its presence was also symbolic to doula participants. It was a constant reminder of an influence on the mother's labor, and was usually the beginning of a cascade of interventions. Rejecting the IV can be seen as mutinous in more controlling environments. Ashley and Stella reported on their experiences.

> Ashley: "But the doctor, he—when the mother refused the IV after awhile and stuff like this, the doctor sent the head nurse. He wasn't going to confront her; he was going to be the nice guy. He sent the head nurse in to read this woman the riot act and tell her she was putting herself in jeopardy and everybody in jeopardy, and 'How can you do this?' …And the husband was like, 'Yes. Uh-huh, uh-huh, uh-huh, yeah, uh-huh. Thank-you. No."

> Stella: "Oh, the great part was, they came in at one point and said, 'We have to start an IV.' And she said, 'I don't want one.' And the midwife was very, like, 'Well!' And Lucy said, 'I'm sorry, I don't want one.' And they said, well, they'd have to sign a paper. And I thought, 'Oh, she's going to give in.' And she didn't, she said, 'Bring me the paper.' And they both signed the paper. And the funny thing is, after it was all over, Lucy told me when she really looked at the paper, it wasn't even the right paper, it was somebody else's name! [Laughs] So the paper didn't do any good."

In both of these instances, careproviders tried to intimidate mothers into having IV's. Neither time did the parents change their minds, and the doulas did not report further negative consequences. However, doulas did not always report positive experiences for parents who made requests. Delia shared two experiences with hospital staff who had priorities other than the patient's emotional wellbeing.

> "It's a hard place to be when a procedure has happened and you don't want to upset the mother, but when they're looking at you with pleading eyes like, 'Don't leave me.' You're going to try, in a non-upsetting way, to stay. And I said, 'I'm employed by this couple and I need to stay through this procedure. And my staying might not be the norm, and I'm asking you to bend the rules here a little bit.' Take the nurse aside and discuss that. But it was an absolute, 'No, you must leave', and out the door and shut."

> "Another experience I had was a nurse with another young girl, who only wanted to have a half dose of Stadol or Nubain because she was frightened of the medications. And she geared herself, 'Okay I can have this half dose. A couple of minutes later or an hour later I can have another half dose.' That's how she was guiding her labor, working towards

> her epidural. And so she had this imprinted in this mind. So the nurse came in to give her pain meds and we both said to her, 'And that's a half a dose, correct?' and she said 'Yes'. Well, an hour goes by and she wanted her other step in the process of her birth, we asked for it and she said, 'Oh no, she can't have it, we've already given her the whole dose.' And I said, 'Excuse me? She asked for a half a dose. How could you do that? Didn't you state this to her?' And I'm doing this outside from where my client is laboring so she's not hearing any of this. And she said, 'That is the nurse's call, that is not your call.' And I said, 'You're wrong, that is the patient's call, not your call."

When things like this happened, doulas reported their priority was emotional support of the mother, helping to restore feelings of safety. She had to do this while not showing animosity to the nurses, who might have continued to act negatively towards her client. Further advocacy was tempered by this awareness. In this next excerpt, Camille felt that the nurse acted spitefully when the mother's requests were granted by the doctor.

> "The most striking instance I ever had was somebody who, the birth actually went, it was pretty easy. And the doctor had been fine with, for instance, not having an IV. And I really felt that the nurse was trying to make their hospital policy or the doctor out to be the impetus behind her wanting to do certain things, when in reality we had kind of already gotten the okay for certain things. And we just, that final thing, she had a copy of their birth plan and I just remember her kind of looking at me, because she goes to hand the baby and the baby has like the gloppy stuff all over the eyes and she was like, 'Oh, I forgot.' You know I felt that she sort of purposefully put the erythromycin in when it was pretty clear. But I think because I had said, 'Oh, and just as a reminder, they're hoping not to have blah-blah-blah-blah-blah.' And she kind of did it anyway. And I think it was, you know, I don't know. And one of those like, 'Oh, is there a squat bar handy? We're hoping to just have that as an option.' 'I'm really kind of busy. I don't know if I can stop to go find it,' kind of thing. So whatever efforts I made on that day certainly didn't seem to work. But generally, that was pretty clear to me that either she was having a bad day or that was just her feeling on somebody who'd expressed certain preferences."

Camille worked to rationalize the nurse's behavior as she told this story. She tried to make comprehensible behavior that was an anathema to her. Besides Camille and Delia, Sonia, Sophie, Jo Ann and Teresa spoke openly about antagonistic behavior by nurses in response to advocacy by parents. These experiences were formative in developing their current philosophies and practices of advocacy. Sophie counseled for a good patient-careprovider match in

pregnancy. But while at a birth she emotionally supported and "witnessed" procedures that were "clearly medically unindicated, clearly for convenience, clearly hospital insanity".

Effective Advocacy

Effective advocacy was described by doula and mother participants as process-based not outcome-based. In other words, it emerged as defined by the actions and attitude of the doula, not the outcomes of the advocacy process. Doulas considered effective advocacy to include assisting the mother and her birth partner to speak for her needs. It had its roots in a philosophy of empowerment of the mother and belief that she was capable of making good decisions about what was right for her birth. It started with prenatal preparation and understanding of the mother's needs and wants for her birth. Skillful advocacy did not mean giving medical advice, but it did include listing other options and encouraging communication with the medical staff. Sometimes during labor, parents needed reminding that they have a right to ask for their needs to be met or that they could ask for more time to make a decision. They might also have needed reminding that the action recommended by the care provider was something they did not want, or that the current circumstances were a decision making point that had consequences for their birth. Effective advocacy was supporting the mother and her birth partner to speak up if they wished to. It was not speaking for them about their needs to the medical staff. After parents indicated their needs to medical staff, some doulas may have reminded them about parent's wishes, but other doulas did not do this at all. Depending on the circumstances, both behaviors were considered effective advocacy.

Ineffective Advocacy

In this study there were only a few areas where doulas made numerous negative comments, and advocacy was one of those areas. More than just being unskilled, doulas who

had poor advocacy skills actually created significant problems. Through this analysis, it became clear that they had not yet adopted an empowerment philosophy as their core belief in interacting with mothers. Because of this, there were three main negative consequences of their attendance at births: mothers may have felt judged for their decisions; the atmosphere at the birth became less positive; and it left a negative image of doulas in the minds of health care providers.

If these doulas did not believe in empowerment for mothers, then what was occurring? Some doulas were still working through issues from their own births. Others held a view that there was such a thing as an ideal birth, and that their job was to encourage and support the mother in having that ideal birth – not to be empowered as a person. One doula interviewed clearly held this latter belief, and two others were conflicted about it. They were in the process of moving from idealizing "natural childbirth" to realizing empowerment of an individual woman was more beneficial. A few other doulas commented that the process of realizing their own birth history was getting in the way of truly serving mothers. Other experienced doulas talked about mentoring people through this process. Allison, who had been to 23 births at the time of our interview, shared openly about her own experience.

> "You can't do this if you have not healed yourselves, because you will bring your birth to every other birth." And I thought I had. I thought I was really okay with both my births. But what I was doing was judging them because they weren't purely natural births, because I had a Pitocin augmentation in the first one, and I had a two and a half day induction with the second one. And so I didn't have natural childbirth. I was told that by my doula trainers, that the only thing that was natural childbirth was completely un-intervened with, because that was where they were coming from. And it was a place of real anger and judgment and self-hatred."

Because Allison judged herself for not having the natural childbirth she felt was "best", she judged the mothers she attended by that same standard. If they did not make better decisions than the ones Allison did, she felt she had failed and was subtly angry at them. It was not until she came to a place of acceptance about her own decisions and past that she was able to truly be

of service. She spoke about her dawning awareness. "Because my birth was in my head more than her birth. And I was judging her for being a twit and wanting to get an epidural when she told me she was a negative five [very low desire for pain medication]. You know I felt very badly about that." By feeling badly, Allison began the process of self-realization that ultimately ended with her adopting a very solid empowerment framework.

Delia, who had been to 75 births, represented many experienced doulas when she said: "I see a lot of new doulas wanting to correct their own birth experiences. Or control the situation and tell them how they should do it or strongly suggest. 'I strongly suggest' you don't do your epidural now. It's not up to them." Not all doulas progressed through this phase before adopting an empowerment philosophy, but it still can be seen as a predictable challenge.

Another barrier to the development of effective advocacy skills was valuing a certain kind of childbirth as the best experience. Camille, who had attended fifty births in urban New Jersey at the time of the interview, was very eloquent about her shift in values.

> "And so even though I think I intellectually understood that it's not about my right kind of birth, I think it took awhile to really feel that and to really get, have enough experiences with people where you really see, like, 'Wow. This person so benefited from that epidural.' Or, 'This person so benefited, you know, their labor really got better after they had that IV and were hydrated,' or whatever. So I think to—and some additional work that I've done with like *Birthing From Within* and things like that, to really just, I think, get away from being so outcome focused certainly makes, I think makes it easier to do this kind of work. You know, to not feel that you have succeeded or failed if someone else makes certain choices."

Camille used the term "outcome-focused" to explain her past orientation. She explained the change to focusing on the quality of the mother's and family's experience of their birth, not on what interventions took place. During their interviews, several doulas recalled positive experiences from their DONA International trainings especially with the Ideal Birth Exercise.

Each participant takes a few minutes to write down or draw their own ideal birth. Teresa, from Detroit, offered this snapshot from her training:

> "But you start from one place and you view things with your values as to, 'I'd love every woman to have this kind of birth.' You know, that kind of a thing… [Our trainer] went through the whole room, we had to write down the ideal birth exercise. And on the board she's writing every single answer, literally not a spot on the green board left to be written upon. And then, turns around when we're all done and says, 'Well great, it's not your birth though. So none of this matters.' [laughs] We're all like, 'Oh'. You know, what a great lesson."

This exercise is designed so that participants will understand that being a doula is about empowerment, not about whether a mother has interventions or pain medication. It also invites discussion about what agendas or ideas that new doulas have about birth, and that they really do not matter when you are supporting a mother during her labor. Delia commented on this concept further and explained why it was so important:

> "The biggest thing that I would tell somebody is 'it's not your birth'. You know, it's if you feel you have trouble with controlling your own opinion or your judgments on people, then you might want to sit back for a while. Because it's not about you, it's about them. And that would probably be my strongest advice to any new doula. And if you can't provide that for somebody, if you're dead set on not supporting them on pain meds or a physician, then you're not the doula for them and you need to pass it on. And that's an okay thing to do."

> "And you never know what emotional baggage somebody is carrying around. Whether they have graciously confided in you or not, we all learn as we get a little bit more experience the triggers of different backgrounds from people that we can recognize. You just don't know and it's not your right, it's not your birth. And if having an early epidural is the way this woman needs to have her baby or having no pain meds and roughing it out for a very long time and you can't support that, then you need to be quiet."

As can be seen from these excerpts, ineffective advocacy stemmed from misguided intentions and a lack of clarity about what are the most important values in doula work: respecting the autonomy of the mother as her own decision maker and empowerment of the mother by her doula. Many of the doula participants understood these concepts before attending

their first birth, but a minority did not. If they are to stick with doulaing as a profession and be successful, their experiences with mothers and at birth needed to transform them into valuing empowerment. Camille shared earlier about how this shift unfolded for her. Tierney had been attending births for over 20 years in New Jersey. She told a story of how she learned what not to do:

> "I was with a couple and she was having to labor in bed and she was being monitored continuously and the nurse kept pushing the epidural. And finally I just couldn't stand it anymore and I said, 'You know, she really doesn't want the epidural.' It wasn't my place to say that. And the nurse said, 'Well,' and she put me in my place, and said, 'That's not your decision' and da-da-da, and all this stuff. In the end, the woman did opt for an epidural herself, and the nurse was kind of then in that position of, 'See, I told you so. I told you this is what she needed.' And it just set up a really un-level playing field and a loss of credibility, with both the nurse and my client. I mean the client ended up having a good birth, a very positive birth experience."

Tierney learned quite clearly that mothers change their minds as labor unfolds and that part of the awkwardness was that she was not truly accepting of that possibility. When her client decided she wanted an epidural, Tierney had to make up with the client for her misstatement. She tried to communicate that she was open and accepting even though the mother's goals had changed. But it did shift the atmosphere at that birth even though it ended up being positive. Sophie, the New York City doula who spoke earlier about "witnessing" explained her journey:

> "I think early on I had an advocating experience and I got thrown out. Well, I got this close to being thrown out. That was the tip of my pinky finger. So I think that was my advocating lesson. Probably it was lesson after lesson and doing it after doing it and hearing what was real support. Probably by making mistakes. That is, probably, I don't think anybody goes into this work because they're not caring in one way or willing to be present for somebody else. And anybody who goes in with their own agenda isn't going to be doing this work for very long because they'll tear a hospital room apart. They can't do it."

Sophie said her lesson came from getting into conflict situations at births and then "hearing what was real support". She started out "caring" and wanting "to be present" but just did not understand that pushing the staff for what the mother wanted was not "real support". She

had an "agenda", which was to follow the mother's prescribed wishes and get them met for her, rather than creating the space so that her client could do it for herself. Once she figured that out, her practice changed completely. In this next excerpt, Sophie explained in more depth about her point of view. To her, "advocate" means speaking directly to doctors and nurses about the mother's needs whether or not the mother or her birth partner have already expressed them.

> "Part of what I do is damage control. Because I don't advocate and many doulas do, and they do it gruffly I think. So when I go in, the mother's been like told she can't have a doula or you shouldn't, or 'I hate doulas'. So when I go in oftentimes I am doing damage control for doulas who have gone in and turned doctors sour. Who have questioned their care, who have threatened them, who have argued over a mother. The mother's lying there, you're the doctor, I'm the doula, you say what should be done, I don't think so bup bup bup bup bup, back and forth, back and forth, back and forth. While the mother is lying there! What is that?
> So what I have to do is, so the doctor says, 'Let's rupture your membranes because your baby is high in your pelvis and maybe we can get a cord prolapse,' and I just witness it. Or if she says to me, 'Should I do that?' I can say, 'Well if you do that…', with the doctor standing right there. I don't like mothers to say, 'Can you give us five minutes to talk about it and leave the room?' I do not like that, I hate it, because that means when I leave the room, they're going to section her. So anything that is said, I want the doctor there or at least a nurse."

Sophie understood this situation of arguing so intimately because that was the way she used to advocate in the beginning. Now, after attending 500 births and a decade of training new doulas, her perspective was quite different. But she brought up several interesting points. First, she listed the processes of bad advocacy: questioning physician's orders, arguing with medical staff, telling the mother what to do, and asking care providers to leave the room for a private consultation between the doula and the parents. Second, Sophie also mentioned the lack of camaraderie and trust in the labor room between members of the birth team – much of which can be influenced by the doula's behavior. There was also the idea of asking care providers to "leave the room", which implied secrecy or plotting. Some doulas solved this by also leaving the mother and her birth partner alone, but in some situations this was not practical. Lastly, it

introduced the idea of negative consequences for other doulas attending other mothers in the future. Ineffective advocacy lingered on in hospitals, with stories about doulas spreading amongst hospital staff. Teresa from Detroit mentioned the influence of the "bad doula":

> "[There are] philosophies that I don't agree with, non-supportive behavior that I'm thinking [groans] 'Oh, and she's calling herself a doula.' Oh no, you know, it makes us all look bad. You know that's where you get the urban doula legend. She throws herself across the patient so she couldn't get an epidural."

In general, one of the frustrating parts of doula work is that any person can call herself a doula whether or not they have had any training. According to the experienced doulas in this sample, many of the negative experiences of hospital staff had been with people who said they were doulas but had no training or involvement with the doula community. Some were never seen at that hospital again. The doula community needed to respond to this negative experience and convince care providers to work with them again which took time. Doris, a doula from suburban New Jersey, explained:

> "A few years later there was a problem at that particular hospital with what I call, and not generously, doula wannabes. And they had some very, they needed some attitude adjustments and they were very negative about the whole medical scene. And there were some real problems, which I certainly won't go into now, but with a client and then overstepping bounds. And the mother involved was a very good friend of a friend of mine who I had been a doula for [previously]. And so I actually, afterwards I spent a lot of time on the phone processing with her.
>
> But that week when this all happened, because her friend called me to tell me this, and you know, what could she do, et cetera. And I said to my husband, you know, 'I have to, I've got a birth due next week. I'm just wondering what my reaction is going to be when I get there.' He says, 'Hey, they know you. And they know your reputation, they know your skills.' So that was fine. So I did the birth, and I mentioned this to the nurses. And that was virtually what they said, 'Hey, you're not in the same category. We know how you work.' This situation was so bad they actually rewrote the protocol of who could be in the delivery room. I mean this was serious stuff."

There were variations on this story from several doulas all over North America, many who had worked for over a decade. Almost all had to counter negativity from medical staff who

had past bad experiences with doulas, usually over advocacy issues. Earlier it was mentioned that two of the doulas in this study gave examples of advocacy attitudes or behaviors that they considered acceptable. However, they fit the description of ineffective advocacy. The first example comes from Bonnie, who had been to about 25 births and lived in rural Ontario, Canada:

> I've been known to be a straight talker, and I've been known to, I have a reputation of honesty. And so that if, if they, if I was on a, say, the prenatal interview, if they said, asked me—you know, I teach, and for them and for my childbirth classes, it's the same thing, but as a doula too—from a research basis. So I give them the research, they make up the decisions. If they were to say to me, 'Okay, the research says this and this, but what do you think?' Then I would be very honest and tell them what I think about whatever they are. But I would also make it very clear that that is my value system and that what they choose to do is what I will support."

Like other doulas, Bonnie gave her clients information and research to assist their decision-making. However when asked about her opinion, she stated it and then tried to reassure parents that whatever they did she would support. This set up a quandary – the doula said she empowered the parents and supported them, but she had her own opinion too. The parents either chose their doula's choice or rejected it. The path of empowerment meant that a doula did not state her opinion or preference to parents, which left them free to choose. Doulas who practiced effective advocacy, as defined in this study, would interpret the parent's question, "What would you do?", as a signal that they did not have the information they needed. They also gave examples of using active listening skills to help parents clarify their preferences and values. Bonnie had an agenda. She wanted parents to do the right thing, to have that ideal birth, and she felt her preferred choice would help them get it. Stella was a doula who lived in Los Angeles and had attended about 30 births. Her difficulty was slightly more subtle:

> "I still think she could have done it without the epidural. And I tried and I tried. I don't know if there was anything else I could do. I don't think so. Because I had said, you

> know, I'll support you, but I really was very strong when I said, strong in my feeling that she could do this. And I said it to her."

In this excerpt, Stella was asserting to her client that she could do it without an epidural. She did not want the mother to have an epidural, and was conflicted about wanting to support her just where she was. She even said, "I had said I'll support you, but". Her struggle was to be unconditionally accepting while she still wanting the mother to labor without drugs. Lani justified her drug-free preferences in this way:

> "I give pros and cons, tell people – I don't – I try really hard – I mean, they know our philosophy, they know what my philosophy is when they hire me. So they know that I think that they would do better off if they didn't use all of these medications and everything else, they know that, and they still hired me, so obviously it's okay."

Rather than fully accepting mothers for their choices and supporting whatever choices they made, Lani had restricted her practice to people who agreed with her point of view. She justified urging them to follow a natural childbirth agenda because it was part of her philosophy and "they still hired me". Lani felt she still supported mothers fully even if they chose medications or interventions. In her point of view, she could still have an empowerment philosophy and value an intervention-free birth as the ideal. The difficulty with this philosophy was that it still involved judgment. It was not unconditional acceptance. It was acceptance with limits, which was not really acceptance at all. Nor was it empowerment. The philosophy of empowerment held that the mother was the person best suited to make the correct decisions, no matter what they were. The doula's role was to believe in her autonomy and support her goals, not to have her own. Marci, from Sarasota, Florida, made a statement that most doulas agreed with:

> "Another thing that I think is really critical to being a good doula is you have to be, it can't be about you. So there's this, and that's going to, its not like altruistic or something but it does have to be selfless. You have to realize, you have to be able to say, this isn't about me, I'm here for the mom and not worry about yourself on a lot of levels. So you

> have to be able to, I don't know if that is self negating or selfless. But you have to be able to do that."

Mothers Recall Their Advocacy Experiences

After investigating advocacy from the perspective of the doula, the next step is to analyze the narratives of mothers. All of the mother's stories validated the concepts and processes uncovered in the doula accounts. However two mothers also reported mixed feelings about some of their doula's actions, which was the only new theme. It is important to remember that none of these mothers received care from any of the doulas interviewed for this study. One of the primary themes for doulas was to empower mothers in their labors. Not all mothers have this in mind when they hire a doula, although some do. Usually they want a doula to assist in the physical and emotional aspects of labor support without realizing the political aspects of the experience. Of the 10 mothers interviewed, only two, Jeanne and Gail, were explicitly aware before they hired a doula of the need to advocate in a savvy way to draw the kind of care they desired. The others became aware through the process of working with their doula prenatally.

Empowerment. The main theme of empowerment was revealed in the mothers' narratives as they recalled their doula's actions. The empowerment perspective of the doula was apparent in most of the mothers' accounts. However, Jeanne reflected on the meaning of being empowered. Jeanne had the same doula for both her first and second births, and commented on how having a doula with her first baby made her experience so different from that of her friends.

> "I really think that had they had someone there to help them weave through all the information, or had someone there who was just there to support them in whatever decision they made so they felt good with that decision, that their birth experience would have been a different experience. Even if they had to go ahead and get induced, or had to have the epidural, but had someone that made them feel like they were making the right decision with confidence. I think that is totally different than feeling like you're making the decision because you're being forced to make the decision, without really a lot of choice. And that was the impression that I got from my couple of girlfriends who've had those kind of experiences, that it wasn't a decision that they really wanted to make, but

> were forced to make, and not forced in an educated way. Like, 'We're forcing this decision on you because it's really our decision for you, so you're just going to do it.' And I know that their birth experiences with their first children were not very good experiences."

As Jeanne pointed out, the doula's role was to support parents and help them feel good about the decision they made, no matter what decision that was. Preliminary to that was keeping parents involved in the conversation about an intervention rather than having it "forced" on them. There were several experiences that mothers recalled where the doula informed them of their choices, but did not make the choices for them. Alicia described her experience of changing care providers and hospitals:

> "I just started realizing I was feeling increasingly more uncomfortable with my OB. She would say things like, 'I don't know why anyone would want to do this without medication'…I had asked her about a doula, 'What about a doula? Are you guys open to doulas?' and all that. And she said, 'Well, a lot of times the dads feel displaced.' I mean exactly what the books tell you that your doctor is going to say about the doula! It was amazing! So she's like, 'And if you want an epidural, then there's no point. Then the doula has nothing to do but sit around, so there's no point in it.' Because at first I was like, 'Sign me up. I want an epidural the minute I walk in the door.' But then I started doing all this reading and then I was like I really want an unmedicated birth. And I just started realizing, the more research I was doing, that I was not going to be supported, and the hospital I wanted to go to was not going to be what I wanted…So I decided to go check it out, because they have a midwife there. So anyway, at 28 weeks I was having a panic, and I was like, 'I'm going to switch. No, I'm not going to switch.' But I finally, at 28 weeks, went and had a tour and talked to the midwives and stuff, and I switched. And I felt SO good about the experience. My doula, she wasn't like, 'Oh, you should switch.' She was just kind of like, 'Well, if you're uncomfortable there are some options.' So it's really nice that she didn't make me feel pressured and all that. And so anyway, I felt really good when I switched."

It was doulas Lydia from Florida and Sonia from Manhattan who commented on several of their clients who had switched care providers, and how their strategy was to ask only feeling type questions. "How did you feel when the doctor responded to you that way? How do you think they are going to be toward you during labor?" Lani and Tierney, the doula partners from New Jersey, mentioned that mothers "need to take responsibility for their birth experience". If

the physician told them what the standard practice was, and the mother did not like it and did not switch, she made an informed choice. Lani realized that it would not get the mother the birth experience she said she wanted, but "it's not my birth".

Mothers Gail, Georgia and Natalie all gave examples of their doulas giving them options, but not recommending one over another. Natalie had wanted an unmedicated birth with few interventions. Instead she had a very challenging birth with many interventions. Natalie said about her doula: "She would never make the decision for me but she would, like I was just so uncertain about what to do at each of those points, and she would make me feel like I was making the right decision, and helped me to be okay with it." Gail had a similar experience of her doula offering her options. Her labor was also long and challenging, but the offering of choices began while they were still at home. "And [our doula] said, "Well, you have choices,' and she never told us what to do, she just said, 'This is what will happen if you go to the hospital. This is the likelihood if you stay home.' So we decided to stay home." Georgia had a similar issue when her water broke but without any contractions.

> "We talked with her and [the doula] was kind of like, 'Well you can call them,' but she wasn't like, 'You have to call them', I remember she said we could…I think she was worried that they would think it was her fault if we didn't call when my water broke. But we'd never talked to her about my water breaking, so she didn't really – I guess we never said, you know, all I had to say to her was, 'Hey, in my Bradley [childbirth] class we learned this and I already have decided that we're not going to call...She'd had a client earlier in the week that had lied about when their water broke, and she didn't have a problem with them doing that."

Georgia went into labor before the last prenatal meeting with her doula, so there were several possibilities that were not discussed ahead of time. As she recalled it, her doula did not pressure her to do one thing or another. But Georgia was aware of her doula's concerns about being blamed by the hospital staff for Georgia's decisions. Jessie, the client who lied about

when her water broke, was another mother who was interviewed for this study. She explained how her doula, Peggy, helped prepare her.

> "I think Peggy warned me or gave me a heads-up about what potential conflicts there could be, and to be aware of how did I want to handle them, because they could be potential conflicts. And her advice was you don't have to make them into conflicts because this is where the hospital's point of view is coming from, and they're not out to get you and we're not trying to be confrontational, that we have to all work as a team here and we have to respect each other's incredibly diverse approach to all this. You know, from the mother's approach, from the doula's approach, and the hospital's approach."

Half the mothers in this sample gave examples of speaking up to careproviders with their doula's support. For some parents, having the doula in the room was enough. Keiko and her husband arrived at the hospital directly from her doctor's appointment, where they met their doula.

> "I don't think there had been any exam, just, 'Here's your gown. We'll get you into bed. We'll get you hooked up to the monitor. The resident will be in to break your bag.' And that's when my radar – 'What, what are you talking about? We never talked about that.' And she said, 'Well, [Doctor] called with the instructions.' And I said, 'Well then you're going to have to call her back."

Jeanne also had a situation where she had to make a critical decision upon her arrival at the hospital with her first birth. She was met by her assigned nurse who tried to influence Jeanne to do what the nurse wanted.

> "Because she said, 'You have a choice of going to Labor/Delivery or [the Birth Center]. I'll go with you wherever. I'm obviously more comfortable over in Labor/Delivery, but…' And I don't know if having Peggy there gave me enough strength to do it, or if I would have done it naturally. I would hope that I would have been able to do it naturally, just say, 'No, I want to go to the Birth Center and you can come with us.' But I think that there's also having that other person there who, both your husband and, it's almost like having kind of three against one is a lot better than two against one. [Laughs] You know, when there's someone who wants to kind of push you down a direction that you don't want to go."

Both Jessie and Jeanne reported that their husbands felt more comfortable standing up for their wives because of the doula's presence. Jessie said, "Vincent had said right away when we

got in, 'Oh, yeah, we want a drug free birth,' so they knew that right away. So they didn't even offer me any drugs. Vincent vocalized that for both of us." Jeanne remembered it this way:

> "So I had to have an IV. At first they were going to lock me into being in bed, and Joel said, 'There is no way. She will not, she will not make it through if you lock her into bed the entire time.' And he used Peggy to help defend that decision because you know, she knows me so well, as well as him, that they could be my united front on, "No, you need to have me on an IV that allows me to be up and moving." And so they finally relented on that issue."

Mothers also shared that their doula's presence influenced their relationship with their nurses. Vanessa felt that she was helped to communicate more effectively. "She never, she would never actually communicate anything for me, per se. She would ask me the kinds of things I wanted so it would help me to verbalize to the nurses." Natalie also felt positively. "I just felt good having her there because I don't really trust doctors or the whole hospital environment. And I think also having her there kept the nurses from offering drugs and they're being in too much, they just kind of monitored things."

So from a positive standpoint, mothers in this study felt their doulas empowered them to assess their own needs and act on their own behalf. They felt assisted to communicate more effectively and that their doulas positively moderated the relationship with hospital staff. Mothers mentioned an increased understanding of the medical point of view. They also felt their choices were the right ones and had their doulas' support. However, that was not to say that there were not challenges or that everyone involved behaved as expected. Mothers reported conflicts with their physicians, unexpected feedback from their doula, and uncertainty about their own actions. Both Georgia and Gail had emotionally charged birth experiences. Gail cried several times during our interview and Georgia became quite frustrated as she told her story.

Unexpected Conflicts With Doulas and Careproviders. Georgia's labor began three weeks early with ruptured membranes and no contractions. She elected not to call the midwives

but did alert her doula. The next day, Georgia still had no contractions and contacted her doula again. Both Georgia and her husband Bob did not want to go to the hospital. In their discussion, their doula had no preference whether they went to the hospital or stayed home. But she did feel that they needed to be honest with the midwives about what they were doing.

> "But then I felt kind of pressured in the morning, and I was like, 'Honey, I don't know, I feel like she's pressuring us.' And I'm like, 'And then I feel like everything is going to go wrong.' And he said that – so he talked to her, but I should have just said it myself. Because, I don't know what, she kept saying that if we told them that maybe we could work something out with them or something, like she didn't really think – I don't know why, because I mean in my Bradley classes they were like, 'If you call they're going to make you come in.' But she didn't seem to think that that was going to happen. She was like, 'Oh, no, you tell them that you're doing everything.' She just wanted everybody to be honest with each other kind of a thing."

Georgia perceived correctly that Peggy was concerned the midwives would blame her for Georgia's deception. She had a client four days prior to this (another study participant, Jessie) who had also lied about her ruptured membranes, refused treatment, and signed herself out of the hospital against medical advice (AMA). Georgia and Bob did not know this at the time of our interview, and it would have been a breach of confidentiality for Peggy (or myself) to share this information with them. But it is reasonable to conclude that Peggy was concerned about her reputation with the midwives, and wanted to try and be honest if possible. Some of the members of the midwifery group might have felt comfortable with Georgia and Bob's decision, but not all.

Early that afternoon, Bob decided to call the midwives. But he did not get the reception that the doula, Peggy, had hoped for.

> "So we ended up, I really didn't want to call. I was totally stressed out, and so Bob called the midwives. I don't know why we did it, but we called and we said my water had just broken that morning, because we didn't want them to put me on Pitocin. But we had been doing all this stuff, talking to the doula and stuff, and we had all our information from Bradley class how to be careful if your water breaks. But when we called the midwife, she started yelling at Bob. She was like, "I can't believe you called the doula before you called us." Which he never should have mentioned. And then she starts yelling about how we'd waited four hours since the supposed time my water had broken

> and what we were thinking and just...' And he got off the phone with her somehow and then he had to call her back and he was really angry and he said, 'You know, we just really…' She said, 'You better get in here right now.' And he said, 'Well, we're doing everything, we're being really careful. We've done this, this and this. We've been taking her temperature, washed the toilet, everything.' And she said that if we didn't get in there, she said if we didn't get in there soon, they had the right to refuse us care. Which made him really, really mad and made me hysterical. And I was already really stressed because I had had a few contractions but they were sort of vague and nothing really. And so I was just bawling my head off and I was like super tense, because I was just terrified. Because she made me get on the phone and said, the first thing she said was, 'We probably might need to get you on Pitocin.' And I was like, 'Why would you even say that to me? That's not going to make me want to come in.' I guess some people are excited by that. But I didn't want it, which I told her. So after we got off the phone we're like, 'Okay, fine, we'll come in.' I think we said we'd come in, but we hung up. And then Peggy came over—the doula, Peggy—came over. And we all ended up sitting around the table discussing how horrible this was and what we were going to do about it."

Before Peggy arrived, Georgia and Bob called their childbirth class instructor for some suggestions. She came up with this plan, which they eventually followed.

> "Well why don't you just say to them, why don't you just go in whenever you feel like it, and then say to them, 'Sorry, this is the, we got here as soon as we could.' [Laughs] And I thought, oh, that is so funny. Like what are they going to do to us then? We'll just pretend we're totally stupid. So after she said that I like kind of relaxed a little bit."

That evening, Georgia, Bob, Peggy, and Peggy's apprentice, Reba, met at the hospital. The midwives needed to confirm that Georgia's membranes had ruptured so they took a sample and looked at it under the microscope. Even though Georgia had been leaking water since the previous evening, the midwives stated that her bag was not broken and sent her home again. Peggy suggested that Georgia take a calming bath before leaving so that she would want to return when her contractions started. Two hours after returning home, Georgia's contractions began with powerful intensity. Her baby was born healthy three hours later. However, the need to advocate for what they wanted didn't end with their child's birth.

> "At some point she wanted to cut the cord and she's like, "Well…" And we had on our birth plan we didn't want it to be cut until it was white. And I think it was the midwife

> who was like, 'Well, it's almost white. We'd better cut it.' And I was like, 'No, don't cut it.' So finally they did, finally Bob cut it, after it was white or whatever.
>
> Then they said they didn't like his breathing or something. And so I wasn't going to argue with them. So they took him away, just to the other side of the room, and put him under what Bob calls a French fry lamp. One of those really intense, scary things. And I have no idea how long he was gone. Then I delivered the placenta. But I was really upset because I mean I didn't want him to not be able to breathe, but that they took him, you know. And I was like, I hadn't really planned on that. I was like, 'Oh, my baby will be healthy.' But I made Bob go over with them at least.
>
> But then when they brought him back, and I don't know how long he was over there, but when they brought him back, he was like all bundled up. And that's like, for some reason I was like obsessed over that detail. Because I'd been like, you know, they like washed him, I don't know how long he was gone, and then when he came back I was like, I didn't even see him, you know. He just, he had only a head. And they were like, the doulas – or Reba had been over there, and she's like, 'Oh, he has such big hands and feet', and this and that. And I was like, 'Well, I wish I could see.' But then, I don't know why it never occurred to me that I could unwrap him. I mean it was my baby, but for some dumb reason it never occurred to me."

At its heart, Georgia and Bob's story was about advocacy and empowerment. Not only advocacy through words, but advocacy through action. They made choices that their careproviders were not aware they were making. The parents took responsibility by being informed, taking protective action to prevent infection, and choosing when they wanted to go to the hospital. The entire birth was on their terms. Granted, the midwives were mollified by the fact that they did not have evidence that Georgia's waters had broken. They did believe her, but could send her home again as she wished because the test result was negative. However even a woman as empowered as Georgia did not feel she could unwrap her baby. Perhaps it was exhaustion, a desire to not be seen as entirely uncooperative, or that it was unanticipated. Peggy had not had the opportunity to talk to the parents about their newborn preferences and Georgia said she hadn't thought about it much. Whatever the reason, it is interesting that her feelings of empowerment did not yet extend to taking action about her child.

Gail is another mother who had mixed feelings about one aspect of her doula's care. Her labor also began with ruptured membranes and no contractions. She and her husband also chose to stay home and not go to the hospital for a day. Eventually Gail began contracting and was admitted to the hospital but her labor was long and challenging. Gail had wanted an unmedicated birth and had taken Bradley childbirth classes to help her prepare. Her mother was a leader in the natural childbirth movement in the 1970's and is still fairly well known today. Gail was also a nursing professor at a university. All her life she had expected to be able to cope with her labor and have a beautiful birth. To Gail, the decision that she needed pain medication had more significant ramifications for her self concept than for most mothers. During our interview, there were several times when she cried and felt quite conflicted about her birth experience. Her doula understood Gail's deep level of commitment and tried to help preserve her ideal when faced with Gail's assertion that she needed an epidural. Gail's story intertwined the advocacy and emotional support roles of the doula. Here are Gail's words:

> "I never begged or anything, but when I was like, 'I don't think I can do it anymore,' she said, 'Well, let's talk about this.' We talked in between some contractions a little bit, and she said, 'You don't have to have anything, but you might want to try a narcotic to see if that gives you a little bit of rest, to see if that will maybe move the labor along some more if you get some rest.' Because I had had two nights of sleep but I wasn't resting anymore and now it was like 3:00 in the morning. And she said, 'It's okay if you want to try something. It's up to you. Or maybe you want to think about trying not an epidural right away but something more mild that could just wear off.'
>
> And so I said – actually at that point I remember down deep I was thinking, 'I want an epidural. But I don't want an epidural, so why don't I try something else.' So we asked for some Stadol, and so I got—or whatever they were going to have, they said it was Stadol. So I tried that and it did knock me out a little bit and I did get some rest.
>
> …I think if I had gone with my gut, I would have said, 'Fuck you, give me the epidural.' And I would have said, 'This is what I want,' in a very loud voice. …I think the rational side says, 'Well, then you wouldn't have known.' Afterwards I would have been thinking, 'Maybe if I had the Stadol then I could have avoided the epidural.' But at the time there might have been, right now I wonder if I would have felt like that decision was still owned a little bit more by—rather than when I did decide, it was because something

> else hadn't worked and because the doctor at that point was saying, 'We're going to have to go to Pitocin,' and I was like, 'Wait a minute, have a stronger contraction with this?' So there was less degrees of freedom. You know, less room for me to decide. And I was still very relieved, but it was a little less mine. And I think I might have felt a little more ownership if I had said, 'No. You guys, no. No. This is what I wanted.'
>
> So, gentle as they were about it, I let myself be persuaded away from what that little voice was saying, which is, 'Enough is enough. I don't want it, I don't want this pain anymore. I can't.'…And they were holding, like the holding of my other agenda, my earlier agenda. And I always thought my intuition would tell me how to not have any drugs. But my intuition turned out to say, 'That's enough. I can't, I don't want to be in this pain anymore. I can't tolerate it, it's awful. This is awful. This is awful."

Gail's doula understood the mother's deep commitment and had adopted Gail's goals as her own. In general, doulas needed to trust that mothers would state their needs honestly. So there was a balance that was struck every time a mother changed her mind in labor. The doula must discern if the mother needed more support and encouragement to get through a challenging part of the labor, or if she had truly changed her priorities. This was the intersection between the skills of emotional support and advocacy. Advocacy is about helping parents to discover their options and choose appropriately. Emotional support is about empathy and caring. In this case there was an initial mismatch between what Gail wanted and what the doula perceived. But as Gail herself mentioned, she did not honor her own "little voice" and "intuition" and "go with her gut". But she had the knowledge that Stadol could not substitute for the epidural. Like most human relationships, the doula client relationship is complex and fraught with communication challenges. Both bear a responsibility for the resulting experience. However, Gail felt her doula had Gail's wellbeing in mind as she gave her choices. In both Gail and Georgia's stories, neither mother honored their inner voice about what they wanted at one point in their labor. At other times, their decisions were exactly what they wanted and they felt involved and responsible for their medical care. However, for each woman there was one specific incident that stood out when they did not stand up for what they wanted. While Gail was more certain of why, Georgia

had no idea. What is fascinating is that in the scheme of their birth experiences, which each lasted several days, what is memorable are these single incidents.

As we heard in Georgia's story, medical people may not respond positively when patients make independent decisions. Georgia was warned about the perspective of medical people through her childbirth class. She had only one visit with her doula. Jessie, who had the same doula, was featured earlier discussing how the doula had exposed her to differing perspectives. Like Gail and Georgia, Jessie's labor also began with ruptured membranes and no contractions. She elected to stay home for 24 hours before going to the hospital for an exam; however, she explained that her waters had broken only that morning. The physician wanted to admit her and begin pitocin. But Jessie wanted to go home. Her doula, Peggy, was with her and Jessie recalls Peggy's support.

> "I looked at her for support, everyone's kind of saying that you've got to stay, right? This is like a big bad no-no sort of thing, you know? And just looking at her kind of gave me the courage to say, 'Okay, no. This is what I want to do. I'm going to sign myself out and we'll just see what happens tomorrow. I'm not ready to stay here. No way.' Like I wasn't even packed. I knew that if I stayed there I'd just be in tears all night and that would be worse, you know. And I even talked to my OB/GYN too. And Peggy gave me a heads-up and said, 'She's probably going to tell you in very strong, very strong language, not to sign myself out.' So she warned me about that, and then I did get on the phone with her when I was at the hospital there, and it was exactly, yes, it was EXTREMELY strong language. Oh, my God! It was just like, it was like, amazing. Oh, my God! Oh, my God, I could not believe it. I just, I was speechless. I mean I just regained my composure and listened to her, and said, 'Uh-huh, yeah, I realize that but I'm just,' I told my doctor, 'I'm just not, I'm not ready to be staying here.'
>
> So she [doctor] talked to me in a certain language, it was like, 'Oh, my God!' Right? It's like, 'Wow!' It was really something. Oh, crazy, I tell you. Her language was incredibly scary. 'Your baby could die,' is the words she used and stuff like that. And Peggy informed [us] of the strong language she was going to use. I mean Peggy wasn't by any means disrespecting her whatsoever."

Jessie and her husband Vincent left the hospital that day and spent the night and next morning home with few regular contractions. They returned the following afternoon for a

pitocin augmentation and their baby was born five hours later. They did not perceive any negative repercussions for signing out AMA on the previous day.

Conclusion

In all of these stories, mothers experienced their doula's desire to empower them as decision makers, which validated that theme. Mothers also shared experiences of their doulas offering them options without prejudice for a particular choice. They also felt more involved in decision making and spoke up for what they wanted with nurses and physicians. Mothers also reported that fathers felt more comfortable speaking up because of the doula's presence. All 10 mothers mentioned they understood the medical perspective because of their doula, although Georgia indicated she was more influenced by her childbirth class. Their experiences confirm the concepts uncovered in the analysis of doula interviews. Mothers were asked to "tell the story of their birth experience" and if "there were any times they felt unsupported by their doula". So the excerpts here were all part of the mother's spontaneous significant memories rather than responses to a pointed question.

In addition to validating doula-derived concepts of advocacy, two mothers also mentioned minor conflicts with their doulas. Georgia felt distrustful of her doula's option of honesty with the midwives and felt the honesty might have been more motivated by meeting her doula's needs rather than what would have been best for Georgia. Gail felt her doula didn't explore what Gail really needed when she said she wanted an epidural. Instead, she suggested a narcotic as a preliminary step. Gail and Georgia also mentioned times when they didn't follow their "inner voice". These two concepts were added to our understanding of the processes of advocacy.