“It’s about the patient.”: Perspectives of Intrapartum Nurses on Working in Collaborative Practice with Birth Doulas

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Preface

The purpose of this preface is to specify the necessary research ethics board approvals obtained to complete this research and to specify my contributions and those of my thesis committee members.

I applied for ethics approval from the initial study hospital's Research Ethics Board to obtain permission to recruit, interview and analyze the data collected for the study presented in this manuscript. Approval was granted in October 2019 (Appendix A). I subsequently applied for the required ethics approval from the University of Ottawa Office of Research Ethics and Integrity, and this permission was granted in November 2019 (Appendix A).

1. Gabriela Morningstar Mizrahi RN, BN, CD(DONA), IBCLC

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I designed this Interpretive Description study with the guidance of my master's thesis supervisor and applied for the appropriate ethics approvals. I conducted the interviews, transcribed the interviews and performed the in-depth analysis of the collected data. I carried out the literature review and reflection of my theoretical allegiances as elements of the study's theoretical scaffolding. I wrote and revised multiple drafts of the present manuscript.

2. Wendy Peterson RN, PhD, PNC(c)

Associate Professor, School of Nursing, Faculty of Health Sciences and Associate Director of the Centre for Research on Health and Nursing, University of Ottawa

Dr. Wendy Peterson, my thesis supervisor, guided the conceptualization and planning of the study. She brought her expertise and experience implementing Interpretive Description methodology, reviewed the questions for the interview guide for data collection and helped

navigate the amendments required to complete the study. Dr. Peterson contributed to the data analysis process by reviewing all the interview transcriptions and discussing ongoing and final interpretations. She reviewed each chapter of this manuscript and provided constructive feedback for improvements and was integral to the completion of the study and this final manuscript.

3. Josephine Etowa RN, PhD

Full Professor, School of Nursing, Faculty of Health Sciences, University of Ottawa

As a thesis committee member, Dr. Josephine Etowa offered guidance regarding the overall design of the study and brought her diverse clinical experience and research knowledge to the discussion of the initial and final data interpretations. She also critically reviewed this manuscript and provided feedback which strengthened the theoretical scaffolding of the study regarding the differentiation between labour support provided by nurses and doulas.

4. France Morin RN, MScN

Clinical Manager, Family Birthing Centre, Montfort Hospital

As a thesis committee member, France Morin was instrumental in assessing the feasibility of the study design for the intended setting and implementing the initial recruitment strategies. She brought her current clinical expertise in discussing the initial and final data interpretations, as well as critically reviewing this manuscript.

Abstract

Birth doulas offer continuous physical, emotional, and informational support before, during, and after birth. There is strong evidence of the maternal health benefits associated with continuous labour support. Nurses are the most common intrapartum care provider and navigate the overlapping labour support role with doulas. While there is evidence of mutual respect, conflicts can occur with negative consequences. This study aimed to explore collaborative practice between nurses and doulas from the perspective of intrapartum nurses in Ontario, Canada. Thorne's qualitative interpretive description (ID) methodology was used. Nurses experienced in working with doulas were recruited via email invitations and postings on a nursing online forum. Semi-structured 1:1 interviews were conducted with six nurses. Experience ranged from 4 to 35 years across nine hospitals. Interviews were recorded and transcribed verbatim. Data analysis was informed by the ID approach. Findings comprised two main themes, each with four sub-themes. First, participants described *influences on nurses' readiness to collaborate with doulas*. These influences include the *culture clash* between medicalized and natural birth, *support from management and hospital policies* and *previous professional experiences*. These led to the nurses' approach, *"it's about the patient"*. Second, participants' responses reflected a *continuum of nurse-doula collaboration*, beginning with *being open-minded*, a necessity for *getting on the patient's team*, *building trust* and *working together towards shared goals*. These findings provide a framework for interventions to facilitate collaborative practice, including in-service training and enactment of appropriate institutional policies. Improved collaboration enhances both nurses' and doulas' practice while promoting better childbirth outcomes.

Acknowledgements

I would like to offer immense thanks to my thesis supervisor, Dr. Wendy Peterson, who graciously accepted to share her expertise when I approached her with my initial research idea. I am forever grateful for her unwavering support, patience, encouragement, and for offering me the opportunity to pursue my passion for evidence-based maternity care both through research and through sharing my skills and passion for labour support, doulas, and humanistic birth with her undergraduate nursing students. I feel honoured and privileged to have worked with a mentor who from our first meeting took the time to share her incredible knowledge, experience, and passion for maternal-newborn health, who respected my goals, who opened the door to more nursing research possibilities, and who was committed to my success.

A very special thank you to my committee members, Dr. Josephine Etowa and France Morin, for their willingness to support me in the pursuit of this thesis research, for sharing their knowledge and expertise, and for taking time to offer valuable feedback throughout the process.

I would like to express great gratitude to the six nurses who shared their experiences and insights about how they skillfully care for their labouring patients accompanied by doulas.

I am very thankful for the University of Ottawa Admission and Excellence Scholarships, the Ontario Graduate Scholarship and the Canada Graduate Scholarship from the Canadian Institutes of Health Research, which supported me in pursuing this degree and thesis research.

Lastly, I would like to thank my wonderful family for their unfaltering support, encouragement, and patience, and for always giving me the boost I needed to keep moving forward. A special thanks to my mom for reading the same chapters over and over…and over, as I gradually put together the final version of this manuscript and to my dad for always encouraging me to be a “super nurse”.

Chapter One – Introduction

It was just after 7:30am. The day shift had just begun. I had already seen two shift changes, four nurses and three doctors, but I was not going home yet. As the doula, I was staying with my labouring client no matter how many shifts went by. It had been a long night of induced labour for my client and her partner. I had accompanied many families through this journey before. This time, it was not the labour that particularly challenged my abilities. Rather, it was being confronted with ambivalence or animosity before even having a chance to get out a "Hello, my name is Gabriela. I'm a DONA certified birth doula." However, I was determined to be professional, respectful, and work with the healthcare team as best as I could in caring for our mutual client. Sleep deprived and hoping that the new day shift would bring a new friendly face, the new day nurse brought relief and a fresh start. She was the breath of fresh air, the competent, respectful, calm, and caring nurse we had been waiting for. As I left the room for a water refill, the nurse found me and asked if the client and I had discussed how she wanted to push. It took a moment for me to compute what was happening. The nurse actually wanted to work together and know the client's wishes! It was the first time a nurse had done this since we arrived. The first time a nurse used me as a source of information to know more about the client's wishes and the first time a nurse had shown such an effort to collaborate. Perhaps it was the sheer exhaustion that made this event stand out in my mind, but this interaction and working collaboratively with this nurse for the duration of the client's labour made me wonder what made this interaction so positive? What made this nurse's approach different?

I began to think through all my experiences of working with intrapartum nurses when I accompanied my doula clients. During doula training, we learned about working with the healthcare team. I searched the literature further for existing best practice recommendations. I

wanted to know if there was anything doulas and nurses did or could do that would facilitate collaborative practice between nurses and doulas in the hospital setting. During this search, I noticed that there were no existing peer-reviewed qualitative studies particularly looking into nurses' perspectives of working with doulas.

I was a registered nurse before becoming a doula. I went into doula training thinking that it would add to my labour support skills, but it opened my eyes to the wealth of evidence regarding the positive impact of doula support and made me passionate about advocating for more widespread access to this evidence-based practice and raising awareness about the wealth of supporting research.

Although I knew I wanted to pursue a master's degree in nursing, I did not know that my experience working as a birth doula in private practice would lead me to the future topic for my thesis. I wanted to investigate the nursing perspective of working with doulas, since nurses are the health professionals who spend the most time with women in labour in the hospital in North America and work most closely with doulas (Zielinski et al., 2016). Furthermore, I had experienced this collaboration from the doula perspective, but I had never experienced it as a nurse working with a patient accompanied by a doula. I wanted to learn more about how nurses work in collaborative practice with doulas and use these insights to inform best practice recommendations and training for intrapartum nurses about working with doulas.

Research Problem

Intrapartum nurses have many responsibilities in providing holistic care to parturient women and their families during labour and birth, including providing labour support. Birth doulas' primary function is to offer continuous physical, emotional, and informational support before, during, and after birth. Doulas and nurses share the common goals of promoting quality

patient-centred care and optimal birth outcomes for mother and baby (Ballen & Fulcher, 2006). The primary goal of nurses is to ensure the safety of mother and baby, while the primary goal of doulas is to ensure that the mother feels safe and confident (Ballen & Fulcher, 2006). As nurses are the most common intrapartum care provider, they face navigating this overlapping labour support role with doulas (Ballen & Fulcher, 2006). While there is evidence of mutual respect as well as doulas and nurses having mostly positive attitudes towards each other (Eftekhary et al., 2010; Roth et al., 2016), conflicts can occur in the hospital setting with negative consequences (Eftekhary et al., 2010; Neel et al., 2019; Roth et al., 2016). There are many evidence-based benefits of birth doula support for maternal and neonatal outcomes, such as shorter labours, increased spontaneous vaginal delivery, decreased caesarean section and instrumental birth and more positive view of the birth experience (Bohren, et al., 2017). It is also important to consider the consequences of interprofessional conflict between doulas and nurses on parturient women, which are notably the resulting; (a) maternal physical stress response and its effect on labour progress and fetal wellbeing; (b) the patients' compromised trust in the healthcare team, making care delivery more difficult and negatively colouring patients' perceptions of interactions with healthcare team members; and (c) the increased likelihood of a more negative view of the birth experience (Eftekhary et al., 2010; Papagni & Buckner, 2006). In view of the research supporting the benefits of birth doula support and the noted consequences of interprofessional conflict, there is a need to investigate this issue in greater depth to inform best practices, in order to facilitate and promote greater collaborative practice between nurses and doulas in the intrapartum hospital setting. Previous research has explored the perspectives of healthcare providers (HCPs) on working with doulas; however, they have not specifically focussed on the nursing perspective (Akhavan & Lundgren, 2012; Klein et al., 2009; Lucas & Wright, 2019; Neel et al., 2019;

Stevens et al., 2011). The qualitative study presented here seeks to fill this knowledge gap and focus on the perspective of nurses as they are the HCPs who spend the most time with labouring parturient patients in the hospital setting (Zielinski et al., 2016) and therefore spend the most time working directly with the accompanying birth doula.

Research Purpose

The purpose of this study is to explore collaborative practice between intrapartum nurses and birth doulas in the hospital setting from the perspective of nurses.

Research Objectives

Within the intrapartum hospital setting in Ontario, Canada:

1- To illustrate intrapartum nurses' descriptions of collaborative practice with birth doulas.

2- To examine how nurses learn to work in collaborative practice with doulas.

3- To describe the contextual factors that influence collaborative practice between nurses and doulas, from the perspective of nurses.

4- To inform nursing best practices for working with patients who are accompanied by their doulas.

Implications for Nursing

With this study, I aimed to explore and further understand collaborative practice between nurses and doulas in the intrapartum hospital setting from the perspective of nurses. The findings from this study will provide valuable insights from the individuals involved. The resulting interpretive description of how nurses and doulas work together in the hospital setting, including determinants that influence collaborative practice, can be used to inform interventions to promote greater collaborative practice between nurses and doulas (Duggleby et al., 2020). This serves as a step towards ensuring that nurses are better prepared to work with doulas, and

parturient women accompanied by a doula can enjoy the full benefits of the support provided by their doula and their intrapartum nurses.

Clarification of Terms and Concepts

Collaborative Practice

In this thesis, "collaborative practice" refers to the way nurses, doulas, and other HCPs with different backgrounds can work together to provide optimal care to patients, families and communities and improve outcomes (World Health Organization, 2010, p.7). In the *Framework for Action on Interprofessional Education and Collaborative Practice*, by the Health Professions Networks Nursing and Midwifery Office within the Department of Human Resources for Health of the World Health Organization (WHO), the authors further explain that collaborative practice "allows health workers to engage any individual whose skills can help achieve local health goals" (World Health Organization, 2010, p. 7). This goes beyond the actions of individual HCPs and ultimately strengthens health systems (World Health Organization, 2010). It involves interprofessional education, "supportive management practices, identifying and supporting champions, the resolve to change the culture and attitudes of health workers, a willingness to update, renew, and revise existing curricula, and appropriate legislation that limits barriers to collaborative practice" (World Health Organization, 2010, p. 7). The authors note that these individual components are different in each health system and need to be selectively applied and adapted to the unique local or regional context to be most effective (World Health organization, 2010, p.7). An initiative that was effective in one context may not be applicable to another region with different characteristics even if the needs are similar.

Intrapartum Hospital Setting

The "intrapartum hospital setting" is used to encompass all in-hospital birthing units no matter their given name, such as family birthing centres, labour and delivery unit, and mother-child continuum care units. In Ontario, the Provincial Council for Maternal and Child Health (PCMCH) has outlined three levels and lettered subcategories to categorize hospital birthing units based on the minimum required care capabilities of the facilities, including availability of particular services, such as 24-hour availability of obstetricians for complex cases, as well as restrictions and guidelines to indicate when a higher level of care is required (2013). Level I facilities provide only low risk maternal and neonatal care for gestational ages 36 weeks and above (Provincial Council for Maternal and Child Health, 2013). Level II facilities provide low to moderate risk maternal and neonatal care with three subcategories which have additional capabilities to provide progressively higher risk care, up to a minimum of 30 weeks gestational age (Provincial Council for Maternal and Child Health, 2013). Level III facilities have high risk maternity and neonatal capabilities and cope with births at any gestational age (Provincial Council for Maternal and Child Health, 2013).

Terms Referring to the Birthing Person

Several terms are used to refer to the birthing person throughout this thesis. These include birthing person, woman, parturient, patient, client, and mother.

Doulas

Doulas discussed in this thesis are considered doulas as they were identified as such by the nurses who worked with them. It is unknown what type of training or certification these doulas may have. This heterogeneity and uncertainty of training is reflective of the Canadian practice context, as doulas are not regulated in Canada and doulas can work in several hospitals

with staff that are unfamiliar with their professional backgrounds (de Carvalho Leite & Higginbottom, 2017).

Labour Support

Labour support includes emotional support (continuous presence, words of encouragement and reassurance), physical support (suggested position changes, massage, acupressure, warm compresses, warm bath or shower and other hands on non-pharmacologic comfort techniques), advocacy (helping the birthing person communicate their wishes) and informational support (helping the birthing person get the information needed to make informed choices and keeping them informed of labour progress) (Bohren et al., 2017) .

Midwives

Midwives discussed in this thesis are healthcare professionals funded by the government of Ontario to provide primary care to pregnant women and their newborns throughout pregnancy, labour, birth and the first six weeks postpartum (Association of Ontario Midwives, 2021). Women who choose to give birth with midwives in Ontario can choose to give birth at home, at a birthing centre (in some cities where they are available), or in the hospital where the midwife has privileges (Association of Ontario Midwives, 2021). Midwives are experts in low-risk pregnancy and birth (Association of Ontario Midwives, 2021). If complications occur, midwives can consult or transfer care to a physician as needed according to guidelines set by the College of Midwives of Ontario and the Midwifery Act 1991 (Association of Ontario Midwives, 2021; College of Midwives of Ontario, 2020). Midwives continue to support their clients even after transfer and can resume care if the situation allows (Association of Ontario Midwives, 2021). Midwives are not doulas. Some may have taken doula training and can offer diverse comfort

measures, but their role is that of a primary care provider (Association of Ontario Midwives, 2021).

Thesis Chapters

This traditional style monograph thesis contains five chapters describing the qualitative study undertaken. This first chapter presents the research problem, purpose, and objectives, as well as implications for nursing and a clarification of terms and concepts used throughout this thesis. Chapter Two contains background information on the role of birth doulas, continuous labour support (CLS) provided by doulas and nurses and its benefits, as well as a review of the literature regarding nurses and doulas working together in the hospital setting and their attitudes towards each other. Chapter Three describes the research methodology used in this study. Chapter Four describes the study findings; specifically, the themes identified from the analysis of the participant interview data are explained. Chapter Five presents a discussion of how the research findings add to the existing literature and considers implications for nursing education, practice, policy, and research.

Chapter Two – Literature Review

This chapter presents a review of the literature on nurses and doulas working together in collaborative practice in the intrapartum hospital setting and their attitudes towards each other. The chapter begins with an overview of the roles of intrapartum nurses and doulas in the provision of labour support, followed by the literature on the benefits of continuous labour support (CLS), how CLS works to improve outcomes, as well as an examination of the similarities and differences between the CLS provided by intrapartum nurses and doulas. The chapter concludes with a review of the existing literature on nurses and doulas working together in the intrapartum hospital setting.

Role of Intrapartum Nurses

Throughout history, women have been supported by women through labour; however, when birth was moved from the home to the hospital in North America in the 1900s and became dominated by male physicians, the tradition of having a female lay birth companion was lost (de Carvalho Leite & Higginbottom, 2017). Partners and families were dismissed to the waiting room during this time and were gradually allowed back into the birthing room beginning in the 1980s (The Vanier Institute of the Family, 2017). Today, in Canada, most births, approximately 98%, occur in hospital (Statistics Canada, 2019). Nurses are the most common maternity care provider and spend the most time with the parturient patient during in-hospital labour (Zielinski et al., 2016).

Characteristics of the Labour Support Provided by Intrapartum Nurses

In their position statement, *Continuous Labour Support for Every Woman*, the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) described intrapartum nurses as "[integrating] nursing theory with knowledge and clinical expertise to

provide individualized, patient-centered care for each woman in labor and [coordinating] the woman's support team in accordance with institutional policies to ensure a safe birth." (Association of Women's Health, Obstetric and Neonatal Nurses, 2018). The AWHONN further asserted that "care and support during labour are powerful nursing functions" (Association of Women's Health, Obstetric and Neonatal Nurses, 2018). In North America, almost every birthing person has an intrapartum nurse who is responsible for their holistic care during labour and birth (Zielinski et al., 2016). Labour support provided by nurses has been described in four categories: physical, emotional, instruction/informational, and advocacy (Adams & Bianchi, 2008). The support and guidance provided by nurses to labouring women have the potential to influence the progress of labour and maternal and newborn outcomes (Adams & Bianchi, 2008). For instance, nurses can guide the birthing person in the use of movement and frequent position changes to facilitate comfort and the progress of labour.

In their meta-analysis of women's experiences of CLS during childbirth, Lunda et al. (2018) noted that women most value the emotional support provided by nurses. When nurses provide support in a way that offers encouragement and respects the birthing person's feelings and choices for labour and birth, this positively affects her birth experience (Bohren et al., 2019; Declercq et al., 2014; Low et al., 2006; Papagni & Buckner, 2006). Women also remember when nurses make comments that are not helpful or demonstrate disapproval of their choices, negatively influencing their birth experience (Declercq et al., 2014; Papagni & Buckner, 2006). Lunda et al. (2018) explained that "kind-heartedness and sincerity from the support person facilitated the development of a trusting relationship with the birthing person" (p.9) and good interpersonal relationships promoted positive experiences and enhanced the birthing person's

self-confidence and trust in their support persons, including nurses. Mothers want a constant presence and value companionship in labour (Lunda et al., 2018).

Nurses also support women and families during the vulnerable time of labour and birth by acting as their advocate (Adams & Bianchi, 2008; Zielinski et al., 2016). Adams and Bianchi (2008) described five components within intrapartum nurses' advocacy role. "Conveying Respect" (p.112) included providing complete information, "ensuring privacy, protecting modesty, providing non-judgmental care, and protecting client rights" (p.112). "Acknowledgement of Mother's Expectations" (p.112) encompassed listening to the birth person's wishes, encouraging them to vocalize both positive and negative emotions, facilitating informed decision making by giving evidence-based information, and being aware of one's own personal views (Adams & Bianchi, 2008). For example, the nurse can communicate the patient's wishes to other team members and negotiate on the patient's behalf or remind a provider of the patient's wishes as needed (Adams & Bianchi, 2008). Nurses engage in "conflict resolution" (p.112) and help to de-escalate stressful situations and mediate conflicts between family members by using problem-solving behaviours (Adams & Bianchi, 2008). Adams and Bianchi (2008) also included "partner care" in the nurse's advocacy. Although the birthing person's needs are the priority, it is also the intrapartum nurse's role to assess the partner's expectations and facilitate discussion if these conflict with the birthing person's wishes (Adams & Bianchi, 2008). The intrapartum nursing role in providing labour support is varied. Although it is key, it is only one of many responsibilities nurses fulfill in providing holistic care to parturient women and their families during labour and birth.

Factors Influencing Nurses' Providing Labour Support

Individual and institutional factors can constrain nurses in their ability to provide CLS to the birthing person (Aschenbrenner et al., 2016; Payant et al., 2008; Roth et al., 2016). These include medicalized birth environments where continuous electronic fetal monitoring and other routine intervention protocols reduce the time available for one-to-one labour support, lack of labour support training, understaffing, covering for other nurses on break, and non-nursing duties, such as checking equipment, as well as the belief that a patient with an epidural or a supportive partner does not need the additional labour support from the nurse (Ballen & Fulcher, 2006; Payant et al., 2008). Lunda et al. (2018) explained that "irrespective of all the benefits, continuous labour support is not universally implemented probably due to a high rate of utilising medical interventions, such as epidural anesthesia in hospital settings" (p.1-2; Bianchi & Adams, 2004). Observational studies of nurses working in hospital birthing units have shown that 6.1% to 31.5% of nurses' time is spent providing labour support, while the rest of their time is dedicated to other patient-related activities, such as administering medications, monitoring the wellbeing of mother and baby, documentation and conferring with other HCPs (Gagnon & Waghorn, 1996; Gale et al., 2001; Miltner, 2002).

Furthermore, Payant et al. (2008) noted that "perceived subjective norms may be a crucial element influencing nurses' intentions to provide labor support" (p.411). The culture of the unit could be an expectation that nurses should spend more time providing one-on-one care or conversely there may be a social pressure for nurses not to provide CLS to patients, especially those with an epidural, and instead contribute to covering for nurses going on break or other duties on the unit (Payant et al., 2008). There may also be an emphasis on the prioritization of managing technologies, such as central continuous electronic fetal monitoring or intravenous

pumps, over providing one-to-one labour support (Payant et al., 2008). Lunda et al. (2018) explained that over the last three decades, the adoption of more medical technologies has led to HCPs spending more time managing technologies and implementing routine interventions than offering CLS. In addition, from their focus groups with intrapartum nurses on delayed, unfinished and missed nursing care during labour and birth, Simpson and Lyndon (2016) noted that although nurses consider labour support a significant part of their role, the technical aspects of their role take precedence over providing emotional, physical and informational support when their unit is understaffed. Nurses' ability to provide CLS one-to-one highly depends on institutional factors facilitating and supporting this practice (Bohren et al., 2017; Bohren et al., 2019; Lunda et al., 2018; Payant et al., 2008; Simpson & Lyndon; 2016).

The noted shift to hospital birth with less priority given to providing CLS and intermittent support as the expected norm has left many parents with feelings of isolation and psychological stress (Genesoni & Tallandini, 2009). Consequently, over the last thirty years, there has been an increasing demand for labour support professionals, doulas, who provide CLS and who are independent from the hospital system and are therefore unconstrained by other tasks and institutional protocols (Papagni & Buckner, 2006; Steel et al., 2015). Thus, there has been the emergence of this historical birth practice in a new form through the professionalization of doulas. Today, when labouring women are accompanied by a doula in the hospital, ideally, the doula and the nurses work closely together in caring for their client with mutual respect and appreciation for each other's complex skills, to reach the common goals of ensuring quality patient-centred care and optimal birth outcomes for mother and baby (Ballen & Fulcher, 2006; Gilliland, 2011). This collaboration can be seamless; however, in some cases, conflict can occur

between these two professionals with detrimental consequences for the patient (Bohren et al., 2019; Eftekhary et al., 2010; Neel et al., 2019; Papagni & Buckner, 2006; Roth et al., 2016).

The Role of Doulas

What Is a Doula?

Doula is a Greek word meaning "a woman caregiver of another woman" (Scott et al., 1999, p.1054). The term, doula, was first popularized by anthropologist Dana Raphael in her book *The Tender Gift: Breastfeeding* (1973) to describe women who assisted new mothers from pregnancy through the transition to mothering their newborns. Raphael (1973) primarily described the doula's postpartum role in caring for new mothers by cooking, caring for other children, holding their new babies and providing companionship. The doula could be anyone who could assist the mother through this period of transition from childbearing to confident mothering, such as a neighbour, friend or family member. Raphael (1973) emphasized the social support needed during this time of transition, in particular for breastfeeding. Later studies, such as the seminal work of Sosa et al. (1980), discussed below, went further to describe and investigate the labour and birth support provided by doulas as well.

In recent years, doulas have moved from being an ancient practice where lay persons provided support to mothers in labour to a new concept where expectant families looking for additional support can pay trained doulas to provide continuous support before, during and after birth, including CLS during labour and birth (Steel et al., 2015). Some authors have suggested that the professionalization of doulas has resulted from parents looking for continuity of care from a person that they have known throughout their pregnancy and birth, a model of care which is difficult to find in modern hospital-based maternity care (Dahlen et al., 2011; Steel et al., 2015).

Steel et al. (2015) argued that the term “lay person” which has traditionally been used to describe doulas may not reflect modern doula care. Modern doula care is knowledge-based and doulas follow vocational training before working with expectant families (Steel et al, 2015). Doulas may also continue their professional path by pursuing certification from a particular doula training organization. Steel et al. (2015) explained that due to its traits, modern doula care can be identified as a profession. Furthermore, they asserted that the increasing availability of doula training is further evidence of this professionalization (Steel et al., 2015). Other authors have described doulas who have completed specific doula training as paraprofessionals, since they work closely alongside healthcare professionals (Lantz et al., 2005). Although several authors have discussed the professionalization of doulas, this process is ongoing.

Doulas are not a regulated profession in Canada (de Carvalho Leite & Higginbottom, 2017); however, there are many certifying organizations with which doulas can choose to affiliate, such as Doulas of North America (DONA) International (Ahlenmayer & Mahon, 2015; Roth et al., 2016). Founded in 1992 by Penny Simkin, Dr. John H. Kennel, Dr. Marshall Klaus, Phyllis Klaus and Annie Kennedy, several of whom authored the seminal work on the effects of CLS, DONA International is now one of the most well-known and respected doula training organizations in the world (DONA International, 2020a). Many studies on doulas have been conducted with doulas trained and certified by DONA International, since they have standard training requirements and published standards of practice and a code of ethics (DONA International, 2020b). DONA has been a leader in raising public awareness about the role of doulas and even lobbied for the inclusion of the word “doula” in dictionaries around the world (DONA International, 2020c). DONA International (2020d) defines a doula as: “a trained professional who provides continuous physical, emotional and informational support to a mother

before, during and shortly after childbirth to help her achieve the healthiest, most satisfying experience possible". In today's unregulated context, it is important to remember that the use of the doula title does not automatically indicate that an individual is a trained doula or has any training in labour or postpartum support.

Research about Doulas and the CLS They Provide

There has been increasing interest, in recent years, to investigate the role of doulas and the benefits of the support they provide (Steel et al., 2015). Steel et al. (2015) sought to critically appraise the existing published research regarding all aspects of "trained" and "professional" doulas, citing that "there is a need to examine formally trained and professional doulas as a discrete health provider group" (p.227). The authors explained that previous reviews on the benefits of CLS have included trained doulas but have not specifically selected studies which investigated trained doulas exclusively (Steel et al., 2015). For the purpose of their review, Steel et al., (2015) defined doulas as "an individual who has undergone training and established a fee-for-service agreement with a woman to provide doula care during the antenatal, intrapartum and/or postnatal period, and this distinguishes from individuals providing untrained, informal or non-specific continuous labour support" (p.226). Steel et al. (2015) identified 48 articles published between 1980 and 2013, which met their inclusion criteria, and of these, 28 articles were published between 2007 and 2013. The authors grouped these articles into four themes of research: workforce and professional issues, trained doula's role and skills, medical outcomes of trained doula care, and social outcomes of trained doula care (Steel et al., 2015). The first study they identified, published in 1980, was Sosa et al.'s seminal work on the effects of CLS on birth outcomes. Sosa et al. (1980) investigated the effects of the presence of a "supportive lay woman ("doula")" (p.597) on the labour outcomes and mother-infant bonding behaviours of women who

would have otherwise laboured alone in a hospital in Guatemala. This was at a time when family members and partners were not universally permitted into the labour and delivery suites in hospitals, as is the more common policy today.

Since Sosa et al.'s (1980) study, many more researchers have turned their attention to the study of lay birth companions, and more recently to trained birth doulas in contexts where they are present in addition to nurses, midwives, partners, other family members or friends and not instead of this support; thereby providing evidence of the added benefit of doula support in addition to the existing support team (McGrath & Kennel, 2008). Steel et al. (2015) noted that researchers are shifting their attention to the study of trained doulas and the doula model of care. The authors also identified several gaps in the literature on doulas that could benefit from further research (Steel et al., 2015). Of note, the authors identified the need to further explore the perspectives of maternity healthcare providers regarding trained doula care.

Additionally, doula research may also be gaining academic attention because of evolving maternity care practice and dominant birth culture (Steel et al., 2015). The legalization and regulation of midwifery in Ontario with the establishment of the College of Midwives of Ontario on January 1, 1994, subsequent to the Midwifery Act (1991), is perhaps another change that has led to increased interest in the effectiveness of continuity of care and CLS (College of Midwives of Ontario, 1994; Midwifery Act, 1991). Other regulatory professional bodies, such as the Society of Obstetricians and Gynecologists of Canada (SOGC), have progressively published recommendations focussed on patient-centered care, emphasizing physiologic birth, and acknowledging the holistic needs of parturient women (American College of Obstetricians and Gynecologists & Society for Maternal-Fetal Medicine, 2014; Lee et al., 2016; Liston et al.,

2007). Furthermore, these policies have brought forward models of maternity care that encourage interprofessional collaboration to optimize birth outcomes and foster positive birth experiences.

The Benefits of Continuous Labour Support Provided by Doulas. Continuous labour support (CLS) provided by doulas has many benefits for parturient women (Bohren et al., 2017; Campbell et al., 2006; Fortier & Godwin, 2015). The focus of many studies has been the effects of CLS provided by lay birth companions or trained doulas; however, Steel et al. (2015) highlighted that the evaluation of the effects of trained doula support on birth outcomes has not used consistent definitions of the trained doula support (Steel et al., 2015). The lack of a consistent conceptual definition of doula support has made it more difficult to decipher how CLS provided by a trained doula affects birth outcomes compared with other providers of CLS, such as, nurses, partners, or friends with a few hours of labour support training. It is important to keep this conceptual ambiguity in mind and critically appraise the published research on CLS provided by doulas versus CLS or intermittent labour support from other providers.

Fortier and Godwin (2015) performed a meta-analysis of the impact of CLS provided by trained doulas on specific birth outcomes. The authors included five randomized controlled trials which met their methodological quality criteria (Fortier & Godwin, 2015). They concluded from their analysis that women who were deemed as having a low-risk pregnancy, who delivered at term and who were accompanied by trained doulas, were less likely to have a caesarean section and less likely to have an instrumental delivery compared to women who were not accompanied by trained doulas in labour and received standard care.

Campbell et al. (2006) performed a randomized controlled trial where women in the intervention group were offered to choose a female friend or family member to follow two 2-hour sessions of doula labour support training based on DONA International training in order to

continuously support the parturient woman during labour. The participants were all nulliparous women with low-risk pregnancies (Campbell et al., 2006). Although this study evaluated the effect of CLS provided by a friend or family member trained in labour support rather than a trained doula, the continuous aspect of the support remains. The authors found that compared to the women who were not accompanied by a trained labour companion, the women who were accompanied by their trained friend or family member experienced significantly shorter labours, had greater cervical dilation at the time of epidural analgesia and their babies had higher APGAR scores at 1 and 5 minutes of life (Campbell et al., 2006).

An updated Cochrane review on the benefits of CLS, included 26 trials which demonstrated CLS as an effective intervention to improve maternal and neonatal birth outcomes (Bohren et al., 2017). The authors defined CLS as continuous provision of labour support "provided at least in early labour (before 6 cm dilation) or within one hour of hospital admission (for admission with greater than or equal to 6cm dilation), through until at least the birth, and provided by a person whose sole responsibility is to provide support to the woman, as continuously as practical in a given context" (Bohren et al., 2017, p.11). The benefits of CLS include, but are not limited to, shorter labours, increased spontaneous vaginal delivery, decreased caesarean section and instrumental birth, and decreased use of analgesia, such as an epidural (Bohren et al., 2017). Also, neonates have higher APGAR scores at five minutes of life, women are more likely to view their birth experience positively, and no harms have been reported (Bohren et al., 2017). This review included studies in which the provider of the CLS encompassed friends, family, healthcare providers and trained doulas. In their conclusions, the authors indicated that CLS was most effective when provided by someone outside the mother's

social circle, who was not a member of hospital staff, and who was trained in labour support, such as a doula (Bohren et al., 2017).

Further studies have evaluated the effect of doula support for marginalized or vulnerable groups. In addition to the aforementioned benefits, women living with low-income who have doula support have been found to have higher rates of breastfeeding initiation and maintenance at six weeks postpartum compared to those without doula support (Kozhimannil et al., 2013; Nommsen-Rivers et al., 2009). Thurston et al. (2019) reported that women living with low resources who were supported by doulas were less likely to have epidural analgesia, less likely to have a c-section and were ten times more likely to initiate breastfeeding compared with the outcomes of all Medicaid births in the same county in Alabama.

Several studies have investigated the impact of community-based doula programs specifically for childbearing adolescents. Although each program is unique, these programs share certain common elements. They each include one or more prenatal meetings, CLS for labour and birth and one or more postpartum meetings (Everson et al., 2018; Gruber et al., 2013; Hans et al., 2013). Women who have been accompanied by doulas in these programs have been found to be less likely to have a low birth weight or premature baby, less likely to experience a birth complication for mother or baby (Gruber et al., 2013), including being less likely to have a c-section, as well as being more likely to initiate breastfeeding than those who did not have doulas (Everson et al., 2018). Gruber et al. (2013) suggested that the doula-supported mothers had a greater sense of self-efficacy regarding their ability to impact the outcomes of their pregnancy thanks to the emotional and informational support provided throughout the pregnancy. Hans et al. (2013) also noted that doula-supported mothers engaged in more positive mother-infant interactions. Mothers responded more quickly to their child's distress and they were less likely to

hold parenting attitudes associated with child maltreatment and poor development (Hans et al., 2013). Hans et al. (2013) noted that "the community doula model holds promise as an evidence-based practice to promote positive parenting attitudes and behavior" (p.453).

How does CLS provided by doulas work to improve outcomes? Many studies on CLS have grouped together CLS provided by various people including nurses, midwives, friends, family and doulas in their study design or review of CLS research (Bohren et al., 2017). However, in their Cochrane review, Bohren et al. (2017) noted that the effects of CLS were most effective when provided by a trained person from outside the birthing person's social circle and not a member of hospital staff. Many researchers have pondered the question why doulas have such a positive effect on obstetric and neonatal outcomes (Gilliland, 2011). Penny Simkin (2018), one of the founders of DONA International and a well-known figure in the birthing community, tried to address this phenomenon by inquiring, "What is it about the doula that improves outcomes more than any other person who provides labour support?" (p.8). She explained that "the doula offers a unique form of labour support that is distinctly different from the care provided by midwives, nurses, or birth assistants" (Simkin, 2018, p.9). Simkin (2018) highlighted three differences between doulas and nurses or midwives:

1. Doulas have no clinical role and they do not perform any clinical tasks or assessments.
2. Doulas are with the woman continuously from early labour until an hour or two after the birth (with the exception of bathroom breaks); therefore, they are able to observe the labour progress as well as the behaviours and emotional state of the labouring person and the others present and change their approach as needed. They are not constrained by other duties and are not responsible for implementing unit protocols or policies.

3. Doulas tailor their approach to “match the mood” (p.10) of the labouring person and communicate with them in a variety of ways. Doulas are aware of their clients’ birth preferences prenatally as well as their changing needs in the moment and are also aware of the greater environment, labour progress, interactions among the staff present and other companions and how these may affect the labouring person.

Although the exact mechanism by which doula support improves birth outcomes has yet to be identified, it is recognized that the birthing person’s emotional state can have a significant effect on her labour (Buckley, 2015; Gilliland, 2011; Simkin, 2018). Simkin (2018) and Bohren et al. (2017) have offered several possible explanations. Simkin (2018) proposed that when doulas are present during labour, the flow of oxytocin is promoted. She explained, “When in labour, women deal with intense emotions, along with physical sensations of pain and extreme effort” (Simkin, 2018, p.9). The doulas’ non-clinical role facilitates the physiologic birth process by ensuring the labouring mother feels safe and competent, so she can let go and follow her labouring instincts, thereby optimizing the hormones needed for labour progress (Simkin, 2018; Buckley, 2015). Doulas are a continuous supportive presence, offering calm reassurance, encouragement, using a soothing tone, mirroring confidence, encouraging the labouring woman to vocalize along with her, rocking silently with her, holding her, using touch and massage, and using various techniques to match the labouring woman’s rhythm (Simkin, 2018). This facilitated flow of oxytocin causes more effective contractions, more spontaneous births and primes parents into an optimal state to bond and care for their newborn. Simkin (2018) further explained,

> [if] the labouring woman feels ‘unsafe’ – from being ignored, criticized, distracted, or treated disrespectfully – or if problems develop for mother or baby – she may be too

> frightened or distressed to release control. This can lead to 'fight or flight' mode, which causes release of high levels of stress hormones (epinephrine, norepinephrine, and others) that may interfere with oxytocin production, labour progress, and fetal wellbeing (p.9).

This is physiologic response to stress in labour is also described by Bohren et al. (2017) and Buckley (2015). The doulas' CLS helps to reduce these stress hormones, so labour is less likely to slow down and risk of maternal and fetal distress decreases (Simkin, 2018). Doulas also encourage the use of movement and position changes which facilitate fetal descent and labour progress (Simkin, 2018). Gilliland (2011) counselled that greater understanding of the complex emotional support and the mother-doula relationship may further elucidate how doulas and the CLS they provide contribute to improved outcomes for mothers and their infants.

Bohren et al.'s (2017) systematic review on the effects of CLS also identified these possible mechanisms. They explained that in modern obstetric care, women are often cared for by unfamiliar staff and are required to give birth in an unfamiliar environment where they are subject to the influences of the particular environment, such as high rates of routine interventions and a lack of privacy, which can affect the birth experience and maternal and newborn outcomes (Bohren et al., 2017). They concluded that CLS may help to mitigate these sources of stress during labour (Bohren et al., 2017). Furthermore, Bohren et al. (2017) noted that CLS can reduce the cascade of interventions that occurs when one initial, perhaps routine, intervention leads to a second co-intervention meant to reduce the adverse effects of the first intervention. However, this second intervention then leads to a third intervention which carries its own risks, and the cascade can continue on further (Bohren et al. 2017). Bohren et al. (2017) discussed the example of epidural analgesia and the role of CLS in reducing the need for epidural analgesia which can

then reduce the need for other interventions, such as, continuous electronic fetal monitoring, augmentation with intravenous oxytocin, medications for hypotension, and instrumental delivery.

Following their systematic review of CLS published in 2017, Bohren et al. (2019) performed a qualitative evidence synthesis of perception and experiences of labour companionship, including 27 studies with lay companions, such as partners, as well as 23 studies with doulas, as defined by DONA International (2020d). This review had three main objectives. First, "to describe and explore perceptions and experiences of women, partners, community members, healthcare providers and administrators, and other key stakeholders regarding labour companionship" (Bohren et al., 2019, p. 3). Second, "to identify factors affecting successful implementation and sustainability of labour companionship" (Bohren et al., 2019, p.3). Third, to enhance understanding of the results from the previous systematic review on CLS (Bohren et al., 2019). As part of the evidence synthesis to address the third objective, the authors developed a logic model demonstrating a possible chain of events to explain how CLS and the actions of the mitigating factors identified in this most recent review led to the identified improved birth outcomes. Bohren et al. (2019) ultimately identified ten themes, divided into three major categories. The first category illustrated "factors affecting implementation" (Bohren et al., 2019, p.21). This included HCPs' and women's awareness of CLS and acknowledgement of its benefits, as well as highlighted that labour companionship is sometimes viewed as less important and deprioritised due to limited resources (Bohren et al., 2019). "Creating an enabling environment" (Bohren et al. 2019, p.21) underlined the necessity of institutional or unit policies that allow for the presence of labour companions. With regard to "Training, supervision and integration with [the] care team" (Bohren et al., 2019, p.21), the authors noted that some doulas expressed that they were sometimes ignored by HCPs or were not adequately involved in

collaborative care and decision-making and felt that HCPs saw them as "working outside the medical system, and were not considered to have valuable knowledge about a woman's labour progress" (Bohren et al., 2019, p.22). Bohren et al. (2019) explained that HCPs worked well with labour companions when they were well integrated into the model of care, but they could be perceived as an additional burden if the HCPs had to manage their presence and provide direction and support, or if the companion interfered with the care process. In the second category, Bohren et al. (2019) echoed the four components of labour support provided by doulas in describing the role of labour companions: *informational support*, *advocacy*, *practical support* (physical support), and *emotional support*. In the final category, the authors delved into women's, male partners' and doulas' experiences of labour companionship.

Birth Doula Use in North America

Several maternity healthcare professional associations have published statements in support of CLS and have outlined the benefits of CLS provided by doulas in practice guideline publications (American College of Obstetricians and Gynecologists & Society for Maternal-Fetal Medicine, 2014; Lee et al., 2016; Liston et al., 2007). See appendix B for details. Although the benefits of CLS provided by a person trained in labour support are well documented, CLS provided by doulas is often the exception rather than the norm (Bohren et al., 2017). The *Canadian Hospitals Maternity Policies and Practices Survey* (2012) administered by the Public Health Agency of Canada included data from 234 hospitals across Canada. In this survey, 87% of hospitals reported that very few patients hired doulas, and the remaining 13% responded that a minority of patients employed doulas (Hanvey et al., 2012). In the United States, only 6% of women reported engaging doulas (Declercq et al., 2014). There are several barriers to access to doula care noted in the literature. These include the cost of services (Lantz et al., 2005; Strauss,

et al., 2015; Strauss et al., 2016), lack of knowledge of doula services and their benefits by patients and care providers, as well as lack of doula availability in certain geographic locations, such as rural areas, and lack of cultural diversity within the doula profession (Kozhimannil et al., 2014). Kozhimannil et al. (2014) noted that "most doulas are white upper-middle class women serving other white upper-middle class women" (p.3). The lack of public healthcare coverage for doula services and the lack of diversity within the doula workforce makes doula support even less accessible for underrepresented and less privileged groups that could most benefit from doula support and working with a doula who speaks their language or shares their cultural background (Kozhimannil et al., 2014).

Additionally, Strauss et al. (2016) suggested that "because the benefits are particularly significant for those most at risk of poor outcomes, doula support has the potential to reduce health disparities and improve health equity" (p.146). In the United States, Minnesota, Indiana, Oregon, Nebraska (Platt & Kaye, 2020) and New York have passed legislation to provide coverage of doula services through Medicaid reimbursement (Strauss et al., 2016; New York State Department of Health, 2019), in an effort to address maternal-infant health disparities. Canadian provincial healthcare does not cover doula services. The average cost for birth doula support in Canada is $300 to $1500 (Hanley & Lee, 2017). Doula service packages vary according to the provider; however, for this fee, doulas typically offer one or more prenatal visits, continuous support during labour and birth, and one or more postpartum visits (Bohren et al., 2019; Simkin, 2012). During the perinatal period, doulas provide emotional support, education and informational support and can connect their clients with local resources as needed, such as prenatal exercise courses or food banks, depending on the individual client's needs (Simkin, 2012). Researchers at the University of British Colombia explored doula support as a

possible tool to reduce adverse birth outcomes, such as prematurity and unplanned c-sections, as well as the cost of the sequelae associated with these outcomes (Hanley & Lee, 2017). Hanley and Lee (2017) concluded that universal coverage of doula services with reimbursement up to $418.67 per birth could reduce health care costs while improving birth experiences and outcomes for mothers and newborns. They explained that from their analysis, a trained doula attending every low-risk birth in British Columbia in 2013 would have saved $267.55 per birth, a total of $10,428,171 savings for the healthcare system, and the savings increased to $418.67 per birth or a total of $17,847,370 when considering the reduction in healthcare costs related to fewer premature births (Hanley & Lee, 2017). The cost savings would disappear if reimbursement went beyond $418.67 (Hanley & Lee, 2017).

Examining Continuous Labour Support Provided by Doulas and Nurses

If one looks closely, the definition of CLS differs between the roles of nurses and doulas in such a way that they can be seen, at once, as complementary (Ballen & Fulcher, 2006) and as overlapping (Roth et al., 2016). CLS provided by nurses has been described as "the nurse being present…nearly all the time, with the exception of breaks" and with the nurse changing after each shift (Payant et al., 2008, p.407). Whereas CLS provided by doulas is continuous, defined as the doula being present "without interruption except for toileting" (p.1056), from the time of admission until the birth of the baby and unrestricted by shifts or regimented breaks which disrupt the continuity of support (Scott et al., 1999). Doulas may also provide early labour support at the client's home and then continue to provide labour support once admitted to the intrapartum hospital unit (Eftekhary et al., 2010). Both nurses and doulas provide labour support that includes emotional, physical, informational support, and advocacy (Ballen & Fulcher, 2006; Bohren et al., 2019; Gilliland, 2011). It is the timing and the characteristics of the labour support

each provides, that distinguishes their labour support roles. The defining features of the labour support provided by doulas is that it is their sole responsibility and is continuous rather than intermittent (Ballen & Fulcher, 2006; Simkin, 2018).

Aschenbrenner et al. (2016) characterized the labour support provided by nurses as professional labour support (PLS) and noted that PLS has not been shown to have the same statistically and clinically significant benefits compared to the addition of CLS provided by a trained lay-persons, trained doulas or midwives. Following their randomized control trial of nurses as providers of labour support in hospitals, Hodnett et al. (2002) explained that CLS provided by nurses, or rather PLS, had no significant effect on the rate of cesarean delivery or other medical or psychosocial outcomes. Bohren et al. (2017) also observed that of the CLS providers included in the studies within their review, only CLS provided by doulas significantly affected the rate of cesarean delivery. Furthermore, nurses trained as doulas and who provide labour support in addition to their clinical nursing duties do not have the same effect on birth outcomes as women who have both a nurse and a doula (Ballen & Fulcher, 2006).

Doulas and Nurses – Unique and Shared Roles

Ballen and Fulcher (2006) summarized the similarities and differences in the roles of nurses and doulas. See Table 1 for details. The authors explained that doulas and nurses have complementary roles, where doulas can help nurses in providing CLS to their mutual clients and focus on the client's non-medical needs throughout labour when the nurse is engaged in other nursing activities (Ballen & Fulcher, 2006).

Table 1

Contrasting the Nursing and Doula Roles

Role of the Nurse	Role of the Doula
1. Clinical tasks – vitals, monitoring fetal heart tones and contraction pattern,	1. Supportive role – no clinical functions.

medications, intravenous access, vaginal examinations, assesses for potential complications.	
2. Consults with physician or midwife.	2. No clinical responsibilities or decisions.
3. Intermittent presence – leaves for meal breaks, to care for other patients, and at change of shift.	3. Continuous presence – Leaves patient's room only for bathroom breaks.
4. May have more than one patient.	4. Stays with one patient throughout labour and birth.
5. Keeps patient informed of the progress of labour, explains what is normal, and what to expect.	5. Keeps patient informed in lay terms of the progress of labour, what is normal, and what to expect.
6. Advocates by communicating patient's desires to physician or midwife.	6. Advocates by helping the patient identify her questions and by helping her to communicate with health care staff. Does not offer direction regarding the woman's approach to labour.
7. Provides intermittent one-to-one comfort measures and reassurance.	7. Provides one-to-one, continuous comfort measures and reassurance, including massage and touch, positioning for comfort, and to facilitate fetal rotation and descent.
8. Documentation responsibilities.	8. No documentation as part of patient's chart May keep own records or write "birth stories" for clients.
9. Has professional legal responsibility for own actions.	9. Follows a Code of Ethics; may be certified.
10. Usually has not met the patient prior to admission to intrapartum hospital unit.	10. Has usually met with patient one or more times during their pregnancy.
11. Usually no contact with patient once she is transferred to postpartum unit.	11. Follow-up postpartum visit, either in the hospital, in-home, or by phone.

Note. Adapted from "Nurses and Doulas: Complementary Roles to Provide Optimal Maternity Care" by L.E. Ballen & A.J. Fulcher, 2006, *Journal of Obstetric, Gynecologic & Neonatal Nursing, 35*(2), p.306. Copyright 2006 by the Association of Women's Health, Obstetric and Neonatal Nurses.

Doulas and nurses share the common goals of promoting quality patient-centred care and optimal birth outcomes for mother and baby (Ballen & Fulcher, 2006). The primary goal of nurses is to ensure the safety of mother and baby, while the primary goal of doulas is to ensure that the mother feels safe and confident (Ballen & Fulcher, 2006). Doulas are charged with

working in collaboration with the healthcare providers, including nurses, in order to support the birthing person in having a safe and satisfying birth experience (Ballen & Fulcher, 2006). In their explanation of different healthcare providers' contributions to promoting physiologic birth, Zielinski et al. (2016) affirmed that "the key to success is collaboration with a common goal, whether individually or collectively" (p.282). Doulas can be both advocates helping their labouring clients communicate their choices and needs and allies to the healthcare team (Ballen & Fulcher; Simkin, 2012). Simkin (2012) noted that many healthcare providers, including nurses, appreciate the additional support doulas provide to the labouring person and recognize the contribution of the doula's presence on women's increased satisfaction with their birth experience.

The Added Value of CLS Provided by Doulas in Addition to Nurses

CLS provided by doulas does not replace the labour support nurses provide to their labouring patients; it has its own defining features and provides additional support to women, families, and healthcare providers to best meet the support needs of parturient women (Gilliland, 2011). Gilliland (2011) emphasized that "mothers with doulas still value their relationship with their midwives and nurses, and still desire their support" (p.530). She also explained that due to "their role, scope of practice, and multiple demands on their time [it is] unrealistic to expect midwives and nurses to meet a mother's emotional needs in the same way that a doula does in a North American context" (Gilliland, 2011, p.530).

The benefits of CLS have been well documented. The added value of CLS provided by trained doulas has also been demonstrated repeatedly (Bohren et al., 2017; McGrath & Kennel, 2008; Zielinski et al., 2016). Doulas' sole responsibility is to provide CLS (Ballen & Fulcher, 2006; Gilliland, 2011; Simkin, 2018). They meet labouring women's voiced need and

expectation to have a support person present continuously throughout labour and birth (Gilliland, 2011; Lunda et al., 2018). Other care team members, including nurses, are also responsible for the medical care and physical wellbeing of mother and baby in labour, which have priority over providing labour support, especially emotional care (Gilliland, 2011; Simpson & Lyndon, 2016). This continuous one-to-one characteristic and focus on social and emotional care have been identified as key components for the improved outcomes associated with CLS provided by trained doulas (Ahlenmeyer & Mahon, 2015; Bohren et al., 2017; Ballen & Fulcher, 2006; Gilliland, 2002; Gilliland, 2011; McGrath & Kennel, 2008; Simkin, 2018). Lunda et al. (2018) also noted that women most valued continuous support and individualised care that matched their needs and wishes, and they felt empowered by being involved in decision-making, which was facilitated through informational support. Ideally, nurses can provide this support; however, due to constraining factors, they may not always be able to do so (Gilliland, 2011; Payant et al., 2008; Simpson & Lyndon, 2016).

Furthermore, Lunda et al. (2018) reported that women favoured support persons with whom they were familiar and comfortable. Women typically choose their doula during pregnancy and meet with them several times prior to the onset of labour (Ballen & Fulcher, 2006). The doula may be the only member of the support team, other than their partner, that the birthing person has met before arriving at the hospital in labour. Even when there is a supportive partner, there is added value to having a trained doula provide CLS. Doulas assist partners to support the birthing person in whatever way they are able and comfortable, and they are present to support the partner as well (Ballen & Fulcher, 2006; Simkin, 2018). Bertsch et al. (1990) observed that doulas stayed within a foot of the birthing person 85% of the time while partners comparatively stayed that close 28% of the time. Doulas also spent more time providing physical

support to birthing persons, and partners' touch was often defined as handholding (Bertsch et al., 1990; Kennell et al., 1991).

Doulas act as mediators between the birthing person and the healthcare team. Women giving birth in the intrapartum hospital setting are in a state of vulnerability during labour and birth and need a mediator to help communicate their wishes to healthcare providers (Bohren et al., 2019; Green & Hotelling, 2019; Lunda et al., 2018). They also act as mediator by relaying information from the healthcare team to the birthing person (Bohren et al., 2019; Green & Hotelling, 2019; Lunda et al., 2018). Lunda et al. (2018) noted that doulas' mediation role facilitated two-way communication and "promoted a harmonious birth environment" (p.9).

CLS provided by trained doulas in addition to nursing care has the potential to significantly improve birth outcomes. Doulas' continuous presence helps nurses to meet labouring women's expectation and need for continuous support in childbirth. It is an opportunity to work together to place the birthing person and their family at the centre of care and proactively create an environment where collaborative practice promotes effectively meeting the evolving needs of individual patients and families. Improved collaboration has the potential to enhance both nurses' and doulas' practice while promoting better childbirth outcomes.

Review of the Literature Examining Nurse-Doula Collaboration

Search strategy

A search of CINAHL, Scopus and Medline databases without year limitations, as well as a hand search of reference lists from relevant articles for further pertinent articles, yielded 15 peer-reviewed articles which met the search criteria. Keywords included doula, nurse, attitude, collaboration, conflict, and Canada. In addition, reference lists from relevant articles were individually hand searched for further pertinent articles. Articles from both Canada and the

United States were included, since the characteristics of the context in which doulas and nurses interact are similar across both countries. Therefore, research performed in the North American context was considered. These similar characteristics include that doulas are not universally covered by public healthcare and doulas are not regulated as a profession in either country (Roth et al., 2016). Furthermore, research performed overseas about doulas is in the context where midwives are the primary maternity care providers both in and out of hospital, where the scope of practice and training of the midwives is different from that of the intrapartum nurses caring for women in labour in North America. For instance, research performed in Australia and Sweden on the perceptions of midwives on working with doulas reflects a different context of care where midwives provide intrapartum care, not nurses, as well as the midwives' training in the midwifery model of care and role of the midwives as primary caregivers (Akhavan & Lundgren, 2010; Stevens et al., 2011). Registered nurses working in the intrapartum hospital setting in Canada and the United States have similar roles within the hospital maternity care context and a similar scope of practice within their individual workplaces. "Canada" was added as a search term in order to capture articles from Canada, since articles from the United States appeared with the original search terms. The detailed search strategy can be found in appendix C and Table 2 contained therein.

Nurses and Doulas Working Together in the North American Hospital Setting

Although nurses and doulas can work together to ensure optimal birth outcomes, doulas are a relatively new presence in the hospital. While there is evidence of mutual respect, conflict can occur between nurses and doulas (Eftekhary et al., 2010; Roth et al., 2016; Neel et al., 2019). Eftekhary et al. (2010) performed a cross-sectional survey to investigate the perceptions and practices of Canadian doulas. The authors reported that 62% of doulas felt accepted by nurses

(Eftekhary et al., 2010). Eftekhary et al. (2010) noted that one third of the doula respondents reported having experienced conflict with a HCP, which included nurses, obstetricians, family physicians and midwives, and 51.2% of these doulas reported that there was no resolution. Results were limited to the occurrence of conflict rather than cause. Conflict can take the form of a verbal discord, non-verbal facial and physical cues of disagreement or disrespect or asking that someone leave the room (Eftekhary et al., 2010; Papagni & Buckner, 2006).

Amram et al. (2014) investigated how doulas adhere to their standards of practice while helping their clients through challenges in labour using a written survey with open-ended questions. The participants were DONA trained and certified doulas and therefore were expected to adhere to the DONA standards of practice. The authors described several areas of conflict between HCPs and doulas in the intrapartum setting. Amram et al. (2014) concluded that the doulas' advocacy and informational support roles could be a source of conflict. Part of the doulas' role was described as facilitating informed choices by facilitating discussion with the HCPs, prompting questions to gain further information, asking for time to discuss with the birthing person, and encouraging the birthing person to voice their choices (Amram et al., 2014). The doulas explained that they provide non-judgemental support and aid their clients to advocate for their choices even if they do not always agree with them (Amram et al., 2014). The doulas also reported that they sometimes felt blamed by the HCPs when the informed decision-making discussion resulted in the patient refusing the suggested intervention (Amram et al., 2014).

Amram et al. (2014) also noted that "there is an unavoidable and inherent conflict in role dynamics because it is the primary role of both the care provider and the doula to provide information" (Amram et al., 2014, p. 101). They explained that when a doula offers information, this can foster mistrust by suggesting that the information the HCP is providing is not evidence-

based or that all the options have not been adequately presented (Amram et al., 2014). Doulas described trying to be "unchallenging" (p.102) in their approach and needing to balance supporting their clients in their choices, thus fulfilling their advocacy role, while also striving to maintain positive relationships with the healthcare team to continue to be welcome in more challenging environments (Amram et al., 2014). Doulas explained that, at times, this meant altering the way in which they provided support to maintain a harmonious birthing environment (Amram et al., 2014). Amram et al. (2014) also noted that "because information giving and advocacy are areas where values and professional roles collide, they invite potential breakdown of communication in the labor room" (p. 102). The authors did not specifically isolate the causes of conflict between doulas and nurses and were unable to seek clarification due to the method of data collection. They suggested that further research is needed to explore the factors that influence whether and how these conflicts occur in practice (Amram et al., 2014).

Papagni and Buckner (2006) performed a qualitative study which provided insight into the consequences of conflict between nurses and doulas from the patient's perspective. Participants' responses regarding the support provided by their nurses were represented in two main themes: "resentment and animosity" and "acceptance and affirmation" (Papagni & Buckner, 2006, p.16). The authors observed that when the parturients were exposed to conflict between nurses and doulas, this had a negative effect on the women's perception of their birth experience, while usually women supported by doulas are more likely to view their experience positively (Bohren et al., 2017). Participants who had nurses who were more accepting and positive towards doulas described their birth experiences in more positive terms (Papagni & Buckner, 2006). The authors also highlighted that emotional stress during labour, such as that

caused by witnessing conflict, results in the release of catecholamines which inhibits the normal progress of labour and decreases placental perfusion (Papagni & Buckner, 2006).

Most recently, Neel et al. (2019) explored HCPs' perceptions of working with doulas in the hospital using a qualitative design. From their interviews with maternity healthcare providers in three hospitals in Rhode Island, Neel et al. (2019) identified factors which facilitate collaboration. Three main themes emerged for facilitating good working relationships: "mutual respect between doulas and hospital staff, education about doulas' training, and clarification of roles on maternity care teams especially among staff with overlapping roles" (Neel et al., 2019, p.1). The authors further suggested that conflicts between HCPs and doulas may be attributed to a disconnect between the hospital's medicalized birth culture and the patient's wishes for a natural birth. However, they analyzed the responses from all types of HCPs together and did not isolate the nursing perspective, as this was not their main focus.

The Attitudes of Nurses and Doulas Towards Each Other

An attitude is a determined way of thinking about something that is learned through one's environment (Roth et al., 2016). Lucas and Wright (2019) performed a scoping review of the literature on the attitudes of physicians, midwives and nurses towards doulas. The authors concluded that there is limited research on HCP's attitudes towards doulas. The following three articles were those included in this review of articles published between 2008 and 2018.

In their survey of Canadian maternity HCPs' attitudes towards birth practices, Klein et al. (2009) found that 25% of nurses had negative attitudes towards doulas, with the remaining 75% having either positive or ambivalent attitudes. Klein et al.'s (2009) results also provided insights regarding where doulas and nurses may agree or disagree about particular maternity practices. For instance, 83% of doulas and 68% of nurses supported women creating birth plans, and they

had similar responses regarding methods to reduce caesarean, with 25% of nurses and 29% of doulas supported women's right to choose a caesarean section even without medical indication (Klein et al., 2009). Other practices included the use of epidural and the safety of vaginal birth. Nurses' attitudes scored between those of the other healthcare providers who were surveyed (Klein et al., 2009). These included obstetricians, family physicians who provided intrapartum care and those who only provided antepartum care, midwives, and doulas (Klein et al., 2009). Doulas' attitudes most closely mirrored midwives' responses and least resembled those of obstetricians (Klein et al., 2009). Midwives leaned towards physiologic birth and less intervention and obstetricians responded more favourably towards interventions and women's less active role in their birth experience (Klein et al., 2009). Klein et al. (2009) noted that nurses' attitudes may reflect their different practice realities and that in their position as intrapartum nurses, they need to be able to balance their own views as well as those of the care providers with whom they work. In addition, the nursing scope of practice limits nurses' ability to initiate certain interventions; however, they are in a position to influence the decision-making process (Klein et al., 2009).

Liva, et al. (2012) performed a secondary analysis of Klein et al.'s (2009) data and identified factors that influence nurses' attitudes towards birth practices, such as doulas. These included workplace characteristics and exposure to their colleagues' attitudes (Liva et al., 2012). For instance, nurses who worked exclusively with obstetricians and in a tertiary centre were more likely to have negative attitudes towards doulas since more obstetricians have negative attitudes towards doulas, compared to nurses who have worked with midwives and have more positive attitudes towards doulas.

Roth et al. (2016) sought to identify factors that influence North American doulas' and nurses' attitudes towards each other using a cross-sectional survey. The authors determined that higher education level, certification, exposure to each other, appreciation for each other's role and collaborative behaviours were significant factors in promoting reciprocal positive attitudes between nurses and doulas (Roth et al., 2016). However, few details were given about the collaborative behaviours. Furthermore, the authors discovered that nurses who worked more hours or who felt overworked and those who preferred performing clinical tasks more than labour support and had more positive views of routine obstetrical interventions had more negative attitudes towards doulas. Along the same line, doulas who had more positive views towards routine obstetrical interventions had more positive attitudes towards nurses. Roth et al. (2016) sought to explain why nurses who were overworked had more negative attitudes towards doulas, since this would appear to be counterintuitive because doulas would alleviate the nurse's workload by helping to provide labour support. The authors suggested that nurses may see doulas as another person that they must keep informed along with the other members of the healthcare team and doulas may be seen as a hindrance to the smooth implementation of unit protocols (Roth et al., 2016). Due to the quantitative design of this study, this explanation was not further explored with the nurses.

In addition, from the results of their survey on factors influencing nurses' intention to provide labour support, Aschenbrenner et al. (2016) noted that nurses' own choice of healthcare provider for the birth of their child, obstetrician versus family physician or midwife, had an influence on their attitudes towards labour support. Nurses who had chosen an obstetrician demonstrated more negative attitudes towards labour support and those who had chosen a midwife had more positive attitudes (Aschenbrenner et al., 2016).

Nurses' Experiences with Doulas within Specific Doula Programs

Deitrick and Draves (2008) performed a mixed methods study to evaluate the supportive role of doulas provided to "inner city women" (p.397) through a specified doula program at two hospitals in Tampa, Florida, and assess the nurses' feedback about the presence of the doulas. The authors performed telephone interviews with ten nurses from the two hospitals about their experiences of working with the doulas. The focus of the interviews was to know how the nurses assessed the doulas' ability to function on the unit and whether they were satisfied with the care their patients received from the doulas. The nurses reported the doulas were competent, helpful and capable of integrating into the hospital environment (Deitrick & Draves, 2008). The findings presented from the interviews did not describe how the doulas were able to integrate into the hospital environment and work alongside the nurses.

Lanning and Klaman (2019) asked nurses from an academic hospital in the southeastern United States who worked with doulas from their in-house volunteer hospital doula program to complete a survey to evaluate participant characteristics and their perceptions of working with the volunteer doulas. The authors reported that all the nurses who responded to the survey agreed or strongly agreed that they had positive experiences with the doulas and regarded the doulas as important members of the maternity care team (Lanning & Klaman, 2019). There were no further details of the nurses' interactions with the doulas, since this was a descriptive quantitative study.

Lanning et al. (2018) evaluated the integration of volunteer doulas from a pre-existing hospital-based volunteer program into the operating room and recovery room for the purpose of facilitating skin-to-skin care during caesarean births. All the nurses who responded to the survey about their experience of this quality improvement initiative reported that they agreed or strongly agreed that they were satisfied with the doulas and that the doulas were well prepared to support

patient in both the operating room and recovery room (Lanning et al., 2018). Although collaboration between nurses and doulas was not the focus of this evaluation, this innovative initiative offers evidence that doulas can work together with nurses in various birth settings, from the delivery room to the operating room and the recovery room.

Existing Practice Recommendations to Facilitate Nurse-Doula Collaboration

Recommendations regarding how to promote collaborative practice between doulas and nurses include role clarification, mutual respect, and increasing nurses' exposure to doulas (Ahlemeyer & Mahon, 2015; Amram et al., 2014; Ballen & Fulcher, 2006; Eftekhary et al., 2010; Klein et al., 2009; Neel et al., 2019; Roth et al., 2016; Waller-Wise, 2018).

Ballen and Fulcher (2006) described the complementary roles of doulas and nurses in providing care to labouring women in the hospital setting and explored three common misconceptions about doulas and two challenges to collaboration between doulas and nurses and discussed ways to improve this collaboration. This was a clinical issues article with the purpose of clarifying the effects of doula support, describing the role of doulas, demystifying misconceptions, identifying challenges and discussing strategies to facilitate collaboration between nurses and doulas (Ballen & Fulcher, 2006). The three misconceptions discussed were the following: "Women laboring with an epidural do not need a doula" (p. 307), "Women who have supportive partners do not need doulas" (p.307), and "Nurses already give labor support to birthing women" (Ballen & Fulcher, 2006, p.307) The authors described "Territorialism and Turf" (p. 308) as a challenge to collaboration, reporting from an anecdotal source and also personally as managers of hospital-based doula programs (Ballen & Fulcher, 2006). They described nurses feeling territorial over their patients, especially when they had not met the doula before, and that nurses' acceptance of doulas depended on their previous exposure to doulas,

which the authors inferred helps nurses understand the doula role (Ballen & Fulcher, 2006). Ballen and Fulcher (2006) also noted "Doulas working outside their scope of practice" (p.308) as a challenge. The authors explained that sometimes nurses feel that doulas dominate the labour and work outside their scope by "giving medical advice and asserting their own opinions and desires, and that patients sometimes turn more to the doula for recommendations than to the provider or nurse" (Ballen & Fulcher, 2006, p.308). The authors did not reference a peer-reviewed study to support this identified challenge, rather they referenced an article from the *Wall Street Journal* which highlighted concern among certain doctors and nurses regarding conflicts with doulas in their practice. Ballen and Fulcher (2006) explained that nurses need to be aware of the avenues available to report grievances when a doula is observed working outside her scope, such as the grievance policies of doula organizations; for example, DONA International's ethics claim policy (DONA International, 2020b). The difficulty is that doulas are not regulated, and not all doulas are certified or associated with a doula organization that has standards of practice and a grievance procedure that the public can access. Furthermore, as noted previously, conflicts with doulas do not appear to arise simply from doulas working outside their scope, but can arise from the doula role itself embodying a natural birth counterculture to the medical model of maternity care (Neel et al., 2019) and the informational support role of doulas working within their scope (Amram et al., 2014).

Ballen and Fulcher (2006) concluded that doulas and nurses have complementary roles and that "doulas can be both advocates who help women voice their needs and desires and allies of the medical facility" (p.308). They presented several recommendations for optimizing collaboration between nurses and doulas, including good two-way communication, developing guidelines for staff to address issues with doulas, encouraging nurses to introduce themselves to

the doula outside the labouring room, and taking time to clarify with the doula what would be more or less helpful (Ballen & Fulcher, 2006). They also recommended that doulas become familiar with the staff and encourage nurses to recognize the labour support knowledge that doulas have to offer which complements labour support provided by nurses, thereby helping to foster mutual respect (Ballen & Fulcher, 2006).

Ahlenmayer and Mahon (2015) advocated that nurses should be knowledgeable about the doula role, scope of practice, training, and credentials, as well as the research on the potential benefits of women being supported by a doula in addition to nursing and partner support. The authors summarized the role of the doula and the training and certification backgrounds that doulas in North America may have from various doula organizations (Ahlenmayer & Mahon, 2015). They also presented the potential challenges nurses may face in working with doulas in the hospital setting and offered recommendations for how nurses and doulas can work together to provide optimal care to meet their mutual patients' needs. These recommendations reflected the authors vision of nurses and doulas having complementary roles and centered on nurses being informed about the doula role and training, being knowledgeable about the researched benefits of doula support on birth outcomes, and establishing relationships and good communication, in order to promote trust and establish mutual goals with doulas based on a patient-centered approach (Ahlenmayer & Mahon, 2015). The authors also highlighted areas for further research, such as the cost-savings potential of hospital-based doula programs and best practices for integrating doulas to optimize patient-centered care and encourage long-term enhanced well-being for mother and baby (Ahlenmayer & Mahon, 2015). Ahlenmayer and Mahon (2015) also suggested that a unified standard for doula training and credentialing would provide credibility

for the doula profession as well as facilitate understanding of the doula role and training for other healthcare providers about doulas, and in this way ease collaboration between doulas and nurses.

In her peer-reviewed commentary, Waller-Wise (2018) explored the overlapping roles of doulas and nurses in the hospital setting which, at times, can contribute to interprofessional conflicts, and suggested multiple interventions to foster collaboration between nurses and doulas based on the four core competencies for collaborative care as described by the Interprofessional Education Collaborative (2016). These competencies are (1) Values /Ethics for Interprofessional Practice, (2) Roles/Responsibilities, (3) Interprofessional Communication, and (4) Teams and Teamwork (Interprofessional Education Collaborative, 2016; Waller-Wise, 2018). These interventions include education, such as a common labour support training for nurses and doulas to share common ground and an offer an opportunity to open dialogue (Waller-Wise, 2018). Another suggestion is for doulas to reach out to nurses and for nurses to reach out to the doulas in their geographic area in order to get to know each other on a more individual level and build collaborative relationships (Waller-Wise, 2018). Nurses can encourage doulas to pursue their certification and even pursue doula training themselves to gain a better understanding of the other's role, open their mind to another point of view and expand their skill-set (Waller-Wise, 2018). Waller-Wise (2018) concluded that in the end, nurses must decide whether to perceive the doula as an ally or as an enemy and choose whether to use strategies to facilitate collaboration with doulas, in order to ensure the provision of collaborative patient-centered care and optimal outcomes for childbearing families.

These recommended interventions have not yet been evaluated for their effectiveness. Several authors have noted that further research with qualitative methodology is needed to explore nurses' and doulas' perspectives on working in collaborative practice (Eftekhary et al.,

2010; Lucas & Wright, 2019; Papagni & Buckner, 2006; Roth et al., 2016). Bohren et al. (2019) noted that further understanding of how various HCPs perceive CLS and elements that impact its integration can provide valuable data to facilitate implementation of this intervention. By speaking to nurses who are experienced in collaborating with doulas in the hospital setting, this study aimed to capture what these nurses already do that helps them to collaborate with doulas, as well as to explore how they learned to work with doulas. Together, these nurses' responses will add qualitative evidence from which practice recommendations can be developed and implemented in a more targeted fashion (Duggleby et al., 2020). The findings from this thesis research support several of the existing recommendations, as well as identify which need to be prioritized in practice. In the next chapter, I will outline the methodological and theoretical considerations for this study exploring collaborative practice between nurses and doulas in the hospital setting from the perspectives of intrapartum nurses.

Chapter Three – Methods

I conducted a qualitative study following interpretive description (ID) methodology (Thorne, 2016) in order to further explore how nurses work in collaborative practice with doulas in the hospital setting. The following chapter encompasses the theoretical and methodological considerations for this study, including an overview of interpretive description, the theoretical scaffolding underpinning the study, as well as the study design, namely the sampling, setting, data collection and analysis procedures, as well as participant demographics, ethical considerations and measures taken to strengthen credibility and trustworthiness.

Research Question

How do nurses work in collaborative practice with doulas in the hospital setting?

Interpretive Description

Interpretive description (ID) is a qualitative research methodology developed by Sally Thorne (2016) to guide the development of knowledge in answering questions raised by applied health disciplines and relevant to the clinical context. This methodology was developed as nursing "needed a research method distinct from the more theoretically driven available social science knowledge development approaches" (p,13) which could guide research intended for an applied health discipline (Thorne, 2016). ID was selected as an appropriate methodology for the purpose of this study, as I was seeking to address particular clinical objectives and looking to uncover new insights from the individuals concerned (Thorne et al., 1997). ID incorporates concepts of the constructivist lens which underpins this study. ID recognizes both the constructed and contextual nature of human experience while also accepting the concept of shared realities (Thorne, 2016; Thorne et al., 2004; Thorne et al., 1997). In the constructivist relativist ontology, truth is understood as being composed of multiple subjective realities located within a given

context and tied to individuals' experiences (Jonassen, 1991; Mills et al., 2006). In this study, I endeavoured to explore the issue from the perspective of nurses. Constructivist epistemology acknowledges the co-construction of meaning resulting from the interaction between researcher and participant (Thorne et al., 1997). Therefore, it is essential to reflect on my existing knowledge and experience and describe my theoretical allegiances which could influence my interactions with participants as well as my interpretations.

Theoretical Scaffolding

Sound theoretical scaffolding helps build the foundation of this ID study and guides the development and decision making throughout the study (Thorne, 2016). Thorne (2016) explained that there are "two critical elements to scaffolding a study" (p.60). First, the literature review provides a picture of what is currently known about the research topic and how researchers have proceeded in studying the issue thus far (Thorne, 2016). This element of the theoretical scaffolding was presented in Chapter Two. Second, researchers must reflect on their "theoretical 'baggage'" (p.61), their beliefs, values, and assumptions, as well as consider the factors that have led them to their current study and locate their position within their discipline (Thorne, 2016). This process of reflection provides researchers the opportunity to explicitly understand their motivations, biases and define the position from which they will conduct the interpretive inquiry (Thorne, 2016). Presented below is a reflection I undertook when developing my thesis research proposal, followed by my theoretical framework, which includes an overview of the key elements of the constructivist lens and the theories which have previously been adopted in studies on nurses' and doulas' attitudes towards each other.

Situating Myself within the Research. I chose to pursue research about collaborative practice between birth doulas and intrapartum nurses due to my background and experience as a

registered nurse and as a certified birth doula. I am a Doulas of North America (DONA) International certified birth doula with five years of experience supporting parturient women in Montreal, Quebec. Most of the births I have attended took place in hospital birthing units. During my doula training, I discovered the wealth of literature about continuous labour support (CLS) provided by doulas. I read several articles about the benefits of CLS and the attitudes of healthcare providers (HCPs) towards CLS in order to better understand what influences their attitudes towards doulas and to be able to tailor my doula practice to better work with HCPs in the hospital. I found little research regarding interventions and no qualitative exploration of the nurses' perspective on working with doulas.

As a doula, I have collaborated with nurses on many occasions and observed that some nurses work seamlessly with doulas to provide patient-centered care and labour support. Others do not appear to know what a doula is, how to work with a patient who has one or seem annoyed at my mere presence even before having a chance to work together. As a practicing doula, I have had a variety of experiences working with nurses and other members of the interprofessional maternity team, including critical situations with fetal decelerations, an emergency forceps delivery on a premature infant, and code pink for severe meconium aspiration with subsequent infant transfer to a level three Neonatal Intensive Care Unit (NICU). My role as a doula in these situations was to keep my client informed of what was happening and offer a calm and reassuring presence. I also have the practice of debriefing with the members of the interprofessional team to receive their feedback and seek clarification regarding what occurred as needed in case my client had questions postpartum. I have never been asked to leave the birthing room and have never received a complaint from a healthcare provider.

As an intrapartum nurse, I have not experienced caring for a patient who was accompanied by a doula during labour. I decided to do doula training because I knew that I wanted to be an intrapartum nurse, and I wanted to expand my labour support skill set. In this way, I would have more pain management options to offer to my patients in addition to the epidural. This is what I saw most often as a nursing student; women given epidurals and left to labour in bed with minimal labour support. Leaving women to labour alone and without more pain management options other than the epidural seemed to go against everything I had learned as a nurse and did not seem to follow the best research evidence.

In my role as a nurse, I have found it difficult to provide continuous hands-on labour support to my patients due to understaffing and having to divide my attention between two patients in active labour, as well as managing all the other tasks involved in a birth when you are the only nurse caring for the patient and assisting the physician. I often felt that I could not give the patient the CLS that may have been helpful to them because I was occupied with other nursing responsibilities and the unit culture did not support staying in the patient's room for prolonged periods and expected nurses to contribute to other unit activities, such as stocking supplies. My unit even had a document that women with a doula had to sign agreeing that if her doula interfered in the hospital's care, the doula would be asked to leave. This seemed to assume that the doula could be a problem and reflected previous issues with doulas on the unit. I also observed some HCPs' resistance to update widely accepted yet outdated routine practices even when presented with the wealth of research for the latest evidence-based practices. For example, the routine use of continuous electronic fetal monitoring without specific indication, restricting food while in labour to only allow clear fluids, routine amniotomy and augmentation of labour with intravenous synthetic oxytocin when labour was progressing normally and mother and fetus

were coping and stable, the universal use of coached closed-glottis pushing, only allowing women to push in lithotomy position with stirrups, no upright positions, and a voiced belief that doulas lead to more caesarean sections. These experiences moved me to learn more about what influences these attitudes towards certain birth practices, specifically how some nurses are better at collaborating with doulas and than others. What made them different? What influenced their attitudes and their approaches? I had not found the voices of nurses in the existing literature about doulas. There were recommendations in the literature for facilitating collaboration between nurses and doulas, but there was no research capturing nurses' current experiences of working with doulas from the perspectives of nurses. I saw this as the missing piece, the missing evidence, to implement changes that could facilitate greater collaboration.

I have an interest in evidence-based maternity care and therefore in promoting physiologic birth practices where possible, as research evidence supports these practices. I integrated this into my clinical practice by ensuring that my patients had as much freedom of movement as possible, even when continuous electronic fetal monitoring was necessary. I helped them use upright pushing positions and open-glottis spontaneous pushing as much as possible. I used the skills I learned as a doula in my practice as a nurse since they are evidence-based and fall within the nursing scope of practice, as well as my unit's policies and protocols.

The clinical perspective I bring to this study centers around the concept of collaborative practice, which has been described as "multiple health workers from different professional backgrounds working together with patients, families, carers and communities to deliver the highest quality of care" (World Health Organization, 2010, p.7). In addition, my view of childbirth and my understanding of the human rights that are to be respected in the provision of health care for parturient women and which ground this study are well summarized in the White Ribbon

Alliance's seven universal rights of childbearing women (Armbruster et al., 2011a; Armbruster et al., 2011b). Every woman has the right to:

1- be free from harm and ill treatment.
2- information, informed consent and refusal, and respect for her choices and preferences, including the right to her choices of companionship during maternity care, whenever possible.
3- privacy and confidentiality.
4- be treated with dignity and respect.
5- equality, freedom from discrimination, and equitable care.
6- healthcare and to the highest attainable level of health.
7- liberty, autonomy, self-determination, and freedom from coercion. (Armbruster et al., 2011a, p. 3-5)

Theoretical Framework. Nursing requires the ability to integrate empirical and technical knowledge. This involves recognizing general patterns while acknowledging the individuality and particular needs of each person and using this knowledge to provide individualized patient-centered care (Canadian Nurses Association, 2017; College of Nurses of Ontario, 2002; Thorne, 2016). Nurses combine both objective and subjective information in order to tailor their approach to individuals' needs and provide nursing care that is competent and evidence based, as well as compassionate and relevant to each individual (Canadian Nurses Association, 2017; College of Nurses of Ontario, 2002; Thorne, 2016). ID incorporates these core nursing concepts which also align with the constructivist lens.

Constructivism. Every individual nurse has beliefs, attitudes, and values that are influenced by their interaction with the environment, including education, unit culture, and

personal experiences. To date, nurses' attitudes towards doulas and how they work together in the hospital setting have been investigated primarily from a post-positivist lens with quantitative methods (Eftekhary et al., 2010; Klein et al., 2009; Lucas & Wright, 2019; Roth et al., 2016). Further research with a qualitative methodology is necessary to explore nurses' perspectives on how they work with doulas in the hospital setting, the influences on their attitudes towards doulas and the approaches they utilize when working with doulas in the hospital setting (Bohren et al., 2019; Eftekhary et al., 2010; Liva et al., 2012; Papagni & Buckner, 2006; Roth et al., 2016).

The constructivist approach allows for greater insight into the nurses' unique views, leading to a deeper understanding of the issue (Creswell, 2009) and identification of areas where change can be facilitated (Thomson et al., 2015; Thorne et al., 1997). Constructivist ontology rejects the existence of one true objective reality and adopts a relativist position where truth is composed of multiple subjectively perceived realities, situated within a given context (Jonassen, 1991; Mills et al., 2006). Epistemologically, constructivism acknowledges the subjective impact of interactions between the researcher and the participant, resulting in the co-construction of meaning (Mills et al., 2006, p.2). Researchers must recognize the influence that their own experiences bring to the inquiry and interpretations and take measures to identify and reflect on these possible influences (Creswell, 2009). This lens favours exploration of the diversity within a phenomenon and uses inductive reasoning to develop knowledge (Creswell, 2009).

Realistic Conflict Theory and Social Identity Theory. In addition to the theoretical underpinnings of constructivism, realistic conflict theory (RCT) and social identity theory (SIT) add theoretical foundation for understanding social interactions and interpretations in this study. RCT and SIT have been used to explore nurses' and doulas' attitudes towards each other by

several authors (Liva et al., 2012; Roth et al., 2016). RCT is a social psychology theory which describes how competition over scarce resources, such as time with the patient, and working towards certain common or competing goals can lead to conflict (Thomson et al., 2015; Sherif, 1966). SIT offers a way to conceptualize professional groups and explains how group attitudes are formed as well as when and how they are acted upon (Trepte & Loy, 2017). In pertinent intergroup situations, individuals will not necessarily act according to their own beliefs, but as members of their "in-group" and their regard for the "out-group" (Tajfel & Turner, 1979). Individuals are motivated to identify themselves as part of a group in order to maintain their self-esteem (Tajfel & Turner, 1979). Self-esteem is enhanced by comparing the in-group favourably to the out-group and acting to preserve their position in the perceived social hierarchy (Pecukonis et al., 2008; Tajfel and Turner's, 1979; Thomson et al., 2015).

Professionals tend to have a greater appreciation of their own role and their own view of the world and tend to overemphasize differences between their in-group and the out-groups (Pecukonis et al., 2008; Thomson et al., 2015). This can lead them to see little difference between individuals within a given profession and between professions other than their own (Pecukonis et al., 2008; Thomson et al., 2015), such as an individual expanding a negative view of midwives to include a negative view of doulas because they are seen as similar and simply not a part of the nurse in-group. The out-group or an individual belonging to the out-group are simply the "other". The resulting stereotyping (Tajfel & Turner, 1979) can lead one negative experience of conflict with a doula, to result in a generalization of doulas, the out-group, as problematic. Thomson et al. (2015) suggested that identifying with one's profession rather than as a member of the interprofessional team can lead to realistic conflict. Profession-centrism

promotes competition rather than collaboration and can result in territorialism (Pecukonis et al., 2008).

SIT and RCT offer a framework that allows for examining the possible incongruity between individuals' own beliefs and their actions in a professional context. Group members may act in a way contrary to their individual beliefs due to a need to align with the in-group in their professional context. For example, if the nurse in-group of a unit has a negative view of doulas or puts little importance on labour support and patient involvement in the birth experience and places more emphasis on following protocols for routine medical interventions, a newly hired nurse may feel inclined to act according to the in-group attitudes in order to bolster their sense of belonging to the in-group and thereby increase her self-esteem in this professional context.

Roth et al. (2016) argued that the labour support roles of doulas and nurses can be regarded as overlapping rather than solely complementary (Ballen & Fulcher, 2006). The doula may be seen by the nurse as competing for the labour support role or time with the patient, and therefore diminishing the opportunities for the nurse to build rapport and trust with the patient, rather than being seen as helpful. According to RCT, the nurse and doula, having internalized their group social identity, are in competition for limited resources, rapport and trust, time with the patient and providing labour support. This territorialism can also be understood as resulting from the need to maintain the nurse group-esteem, prestige and their in-group's position within the perceived hierarchy (Thomson et al., 2015).

SIT and RCT informed the methods of this study, in particular the development of the data collection interview questions. Previous researchers used these theories and related concepts, such as professional culture and professional centrism (Pecukonis et al., 2008), to

explore and discuss the factors that shape doulas' and nurses' attitudes towards each other and to understand the groups' dynamics within the work environment (Roth et al., 2016). This theoretical scaffolding also informed the data analysis as I viewed the data from a position of understanding SIT and RCT as it applies to the topic under study.

Setting

Data collection took place between January and September 2020. The initial setting was an urban teaching hospital in Ontario. This hospital birthing centre presented a unique opportunity, as the nurses work alongside a variety of maternity healthcare providers, including midwives, family doctors and obstetricians and provides services in both official languages to over 1.2 million people in their region ([redacted]2019a). This hospital birthing centre assists with over 3,000 births per year ([redacted], 2019b). It is comprised of 17 birthing rooms and 11 postpartum recovery rooms. There are 84 nurses who are trained to work in labour and delivery [redacted], personal communication, July 15, 2019). These intrapartum nurses are all trained in labour support techniques as part of their standard training to work on the unit ([redacted], personal communication, August 21, 2019). One-to-one nursing is the standard ([redacted], personal communication, August 21, 2019). There is no central fetal monitoring, and the unit culture expectation is that nurses will spend much of their time in the patient's room providing one-to-one care ([redacted] personal communication, August 21, 2019). Some nurses are also trained in postpartum care and the intermediate care nursery ([redacted], personal communication, July 15, 2019).

The setting was subsequently expanded to hospital birthing units across the province of Ontario to include nurses from across the province. This was necessary to continue data collection, as there were no further communications from nurses at the initial hospital interested

in participating in the study after the initial three interviews, and further data was needed to adequately answer the research question. This expanded setting encompassed high risk level three regional facilities as well as low risk level one community hospitals. Additionally, gaining insights from nurses who work in various environments across Ontario was expected to provide rich data and contribute to a greater understanding of how nurses work in collaborative practice with doulas within diverse organizational structures and unit cultures.

Sampling

Initial Sampling

Purposive criterion sampling (Palinkas et al., 2015) was used to recruit intrapartum nurses who have experience working with birth doulas in the hospital setting. Purposive criterion sampling is used to capture and select information-rich cases that adhere to relevant predetermined criterion (Palinkas et al., 2015). Snowball sampling was then used to identify other cases of interest through earlier participants who shared the specified characteristics (Palinkas et al., 2015). Snowball sampling facilitated finding further participants who had experience working with birth doulas in the hospital setting. Snowball sampling facilitated reaching more nurses who could potentially participate in the study through nurses who had already participated as well as nurses who saw the recruitment message and shared it with their nursing colleagues. The nurses who contacted me included information in their email message that explained how they met the inclusion criteria. Purposive sampling was appropriate for this ID study as I was seeking to discover recurrent themes and meaningful overlap within participants' responses (Thorne et al., 1997). Participants were required to meet the following inclusion criteria: be registered nurses in the study's initial hospital birthing centre and have worked at least once with a doula during a birth in the last 10 years. This 10-year limit was

adopted in order to encompass varied work experiences and include enough participants. Nurses who are also trained as doulas were eligible to participate. Nurses who employed a doula for their own birth experience were eligible to participate. Nurses who previously worked at another hospital birthing unit, prior to their current position, where they had experience working with a birth doula at that hospital but not their current hospital birthing centre, were also eligible to participate. Registered practical nurses, nurses who had never worked with a doula, and newly hired nurses being oriented to intrapartum were not eligible to participate. In order to ensure greater transferability of the study findings, only registered nurses were eligible to participate because there is variation between provinces and even between hospitals as to the role that can be performed by registered practical nurses and their equivalents in intrapartum patient care across Canada (British Columbia College of Nursing Professionals, 2019; College of Nurses of Ontario, 2018; Ordre des infirmières et infirmiers auxilliaires du Québec, 2019). Nurses who were being oriented to the unit were not included, as they did not have the experience of being the primary assigned nurse for an intrapartum patient on the unit and having the authority and responsibility as the assigned nurse for a patient while working with the patient's doula.

Modifications to Expand the Sample

By the end of January 2020, I had conducted three interviews with nurses from the initial study hospital, and there were no further communications from nurses interested in participating. In order to collect further data to adequately answer the research question, my supervisor and I decided to expand the inclusion criteria to include registered nurses from across Ontario. Restricting the sample to nurses in Ontario was intended to ensure that participants would all have a common nursing scope of practice and ensure that the other professionals with whom they worked had a common scope of practice, since these can vary between provinces. For instance,

the scope of practice and integration of midwives in the maternity care system is different in Ontario compared to Quebec (Loi sur les sages-femmes, 1999; Midwifery Act, 1991). This amendment to the study sample and accompanying recruitment strategies received ethical approval from the initial study hospital's research ethics board (REB) and from the University of Ottawa Office of Research Ethics and Integrity prior to beginning subsequent recruitment.

The inclusion criteria were also modified to include nurses who have had at least one experience working with a doula in the last 20 years (from the original 10 years). This modification was necessary because finding participants within the existing criteria had been a challenge, and there was an interested nurse who had valuable experiences to share both as an intrapartum nurse and as a perinatal nurse educator which could add important data, but who had worked with doulas more than 10 years ago.

Recruitment

Initial recruitment strategy

Four recruitment strategies were implemented for the recruitment of nurses from the initial study hospital. The study was discussed with one of the clinical managers of the hospital's birthing centre, in order to develop the recruitment strategies. Once granted ethics approval (see appendix A), the following recruitment steps were taken:

First, the clinical manager for the intrapartum nurses at the hospital birthing centre forwarded my recruitment email and poster to present the study to the 84 nurses who work in labour and delivery (see appendices D & E). Reminder emails were sent two weeks and one month later to continue recruitment. The initial email was sent at the beginning of December 2019. Second, recruitment posters were placed on the birthing centre unit in December 2019 (see appendix E). The poster requested that nurses contact me if they were interested in participating

in the study. Third, I briefly presented the study to nurses on each shift on three occasions in January 2020 at times prearranged with the clinical manager, such as during the regular quality care circle at the birthing centre unit. Snacks were provided during these presentations, as recommended by one of the clinical managers of the unit. I offered the nurses the opportunity to ask questions and pointed out the posters that were displayed on the unit. The nurses were encouraged to contact me at the email provided on the poster if they were interested in participating in the study. Finally, each nurse who participated in an interview was asked to identify fellow birthing centre nurses whom they recognized as having worked collaboratively with doulas and may be able to contribute their perspective and their approach to collaborating with doulas. The participants were instructed to give their colleague my contact information and refer them to the recruitment posters on the unit.

A ten-dollar electronic gift card to Tim Hortons was offered to participants in appreciation for participating in the study. This was sent to them by email after completing the interview. The participants were informed that they could keep the gift card even if they chose to withdraw from the study.

Subsequent recruitment strategies

Expanding the study inclusion criteria to include intrapartum nurses from across Ontario required further recruitment strategies. After discussion with my thesis supervisor, I decided to approach the leadership at CAPWHN (Canadian Association of Perinatal and Women's Health Nurses) to ask permission to recruit intrapartum nurses in Ontario through their membership. The CAPWHN leadership initially offered to send a recruitment email to their Ontario members; however, due to the pressures on nurses from the COVID-19 pandemic, they later amended their offer to allow me to post the recruitment message on their members-only online forum (see

appendix F). Nurses who are CAPWHN members can see these posts by logging into the online portal and can also opt to have email notifications for newly posted content. The recruitment message was posted a total of three times at 2–3-week intervals after the initial posting. Nurses who expressed their interest by email and who participated in an interview were encouraged to tell their colleagues about the study and direct them to the recruitment message on the CAPWHN online forum, as well as give them my contact information. Ethical approval for this modification was obtained from the initial study hospital's REB as well as the University of Ottawa Office of Research Ethics and Integrity. In addition, due to business closures during the COVID-19 pandemic, ethical approval was obtained to offer participants a choice between a ten-dollar electronic gift card for Tim Hortons or Indigo/Chapters bookstore, which could be used for online purchases during the pandemic.

Considerations for concluding recruitment

There are no universal set rules for how to determine the most suitable sample size in qualitative research; however, certain factors must be considered: (a) research design, (b) sampling procedure, and (c) the relative frequency of the phenomenon under study (Bradshaw et al., 2017; LoBiondo-Wood and Huber, 2014). Thorne (2016) explained that saturation can never truly be achieved, since the nursing discipline's epistemological orientation prevents us from denying the possibility of further variations beyond those observed in the array of themes which emerged from the latest study. Fawcett and Garity (2009) recommended that a suitable sample size is one that adequately answers the research question, in view that the goal is to collect cases that provide rich information (Thorne, 2016).Taking into consideration the cited factors and the feasibility of completing recruitment in a timely manner since this study must be completed within one year as it is a master's thesis in partial fulfillment of the requirements for the

University of Ottawa Master of Science in Nursing thesis program, I planned to recruit eight to ten participants.

The number of interviews anticipated in my proposal was a tentative estimation which I knew could change based on the subsequent data collection and analysis findings (Bradshaw et al., 2017). The effects of the COVID-19 pandemic on research activities, such as conducting all interviews via Zoom videoconference (but for the first interview conducted in-person before the pandemic) and the challenge of recruiting nurses during a prolonged global crisis were unanticipated.

Recruitment continued until my thesis supervisor, committee members and I agreed that the data collected was rich and sufficient to answer the research question according to Thorne's (2016) standards for ID methodology. A further three nurses were recruited after the initial three participants, for a total of six participants. After a thesis committee meeting in September 2020 to discuss the data analysis, it was agreed that sufficient data had been collected to answer the research question and recruitment could cease.

Data Collection

Nurses contacted me by email to express their interest in participating in the study. After the initial contact, we arranged a mutually convenient time for the interview. Semi-structured 1:1 interviews were conducted using a prepared interview guide in English and French (see appendix G) containing eleven demographic questions, questions pertaining to the context of the participants' work experience, as well as thirteen open-ended questions stemming from the main research question. The interview guide also contained suggested probes in order to encourage participants to give more details. This interview style allows the researcher to gather in depth information on the research topic (Polit & Beck, 2017) and aligns with the underpinnings of ID,

as it invites the sharing of individuals' unique views and experiences (Thorne, 2016). Participants were originally offered the option of conducting the interview face-to-face or via videoconferencing with Zoom (2019). In January 2020, one face-to-face interview was conducted in a private meeting room at the initial study hospital, and the other two nurses opted to participate in the interview via Zoom. The three subsequent interviews performed after March 2020 were conducted via Zoom videoconference, following the COVID-19 pandemic physical distancing guidelines. Participants interviewed via videoconference were asked to choose a location that ensured the privacy of the communication and maintenance of confidentiality, such as a private room in their home.

Zoom (2019) has been used previously in nursing qualitative research to perform semi-structured interviews via distance (Irani et al., 2018). Irani (2019) noted that videoconferencing offers greater scheduling flexibility for participants and may encourage the presence of participants who wouldn't otherwise agree to be interviewed if not for the convenience of the videoconferencing option (Irani et al., 2018). Irani et al.'s (2018) interview participants who chose to do interviews via Zoom videoconference reported positive experiences using this platform as it was easy to use, convenient and allowed for greater flexibility. Participants reported being comfortable in their own space and appreciating not having to set aside time for travelling to a face-to-face interview (Irani et al., 2018). Videoconferencing also retains many of the benefits of face-to-face interviews, such as the ability to see facial expressions and non-verbal cues (Irani, 2019). Both face-to-face and videoconference interviews were audio recorded using an external recorder. I then transcribed the recordings verbatim.

Ethics

This study received ethics approval from the REB at the initial study hospital and the University of Ottawa Office of Research Ethics and Integrity (see appendix A). Participants who contacted the primary investigator by email to communicate their interest in participating in an interview were sent the consent form (see appendix H) by email, to review and sign prior to the interview. Participants were informed of the purpose of the study as well as their right to withdraw and were given the opportunity to ask questions before signing the consent form. Participants who proceeded with an interview via Zoom videoconference were asked to sign the consent form, scan it, and send it back to me. I then signed the consent form and emailed the full signed copy back to the participant. At the beginning of the videoconference, participants were asked if they had any questions about their participation before beginning the interview and were asked to confirm their informed consent verbally before beginning the interview. The written consent form was available in English and in French (see appendix H). Participants were informed that they had the right to refuse to answer any questions throughout the interview. There were no direct risks to the nurses who participated in this study. However, the clinical managers of the initial study hospital birthing centre may or may not have known that a particular nurse participated in the study. Potential participants were assured that their choice to participate in this study would not have any repercussions on their employment.

Confidentiality and privacy were maintained throughout the study. Interview recordings and digital files were saved on my password protected laptop and my supervisor's computer at the University of Ottawa School of Nursing. Physical documents, the signed consent forms, were kept in my thesis supervisor's locked office (UOttawa RGN room 1118). I transcribed the audio-recorded interviews and ensured the transcriptions were de-identified. A master list matching the

participants' names and the numerical codes and pseudonyms were kept as an electronic file in folder separate from the study data on my laptop. Only my supervisor and I had access to the master list. Only my thesis supervisor, thesis committee members had access to the de-identified demographic data and interview transcriptions. The thesis committee member who is also a clinical manager at the initial study hospital birthing centre did not have access to the first three interview transcriptions, since she may have recognized characteristics of nurses from her workplace. My supervisor, thesis committee members, and I signed a confidentiality agreement from the initial study hospital Research Ethics Board prior to commencing the study. Interviews completed via videoconferencing were protected by the privacy features contained in the Zoom platform. Zoom communication is protected by Secure Socket Layer (SSL) encryption and Advanced Encryption Standard (AES) 256-bit algorithm end to end encryption (Zoom, 2019). Zoom has been used previously for confidential interviews for qualitative nursing research (Irani et al., 2018). Participants were asked to choose a location in which they felt comfortable speaking freely and where they could be assured privacy. This was confirmed at the beginning of each interview. Pseudonyms were used when quoting participants in the research findings. Copies of all materials will be kept for a minimum of 7 years, in compliance with the University of Ottawa ethics standards (University of Ottawa, 2018).

Data Analysis

The data analysis was guided by ID qualitative content analysis principles outlined by Thorne (2016) and the inductive content analysis process detailed by Graneheim and Lundman (2004), as is appropriate for ID methodology. Throughout the analysis process, it was important to bear in mind the context in which the themes emerged (Graneheim & Lundman, 2004). The demographic questions and the participants' descriptions of their workplace and work experience

provided essential pieces of this context. Furthermore, I was guided by questions such as "What is happening here?" (p.174) and "What am I learning about this?" (Thorne et al., 1997, p.174) in order to take a global view in interpreting the transcripts as well as to critically reflect on what was present and what was not (Thorne et al., 1997). This ID approach (Thorne, 2016) guided the identification of themes and patterns within the interview transcriptions containing the participants' "subjective perceptions" (p. 5). These themes were then organized into "an interpretive description capable of informing clinical understanding" (Thorne et al., 2004, p. 5).

The following is a description of the analysis process that I followed in working with the collected data. I transcribed all the interview audio-recordings verbatim in the language in which the interview was conducted and de-identified the transcriptions. The participants' names and any identifying information, such as the name of their workplace or names of colleagues, were removed. Each participant was assigned a numerical code. I completed the initial transcription and then verified all the transcriptions by listening to each interview while reading the transcriptions and made corrections as necessary.

Graneheim & Lundman (2004) encourage the researcher to be immersed in the data prior to beginning coding in order to "obtain a sense of the whole" (p.108), as indicated for the ID approach (Thorne, 2016; Thorne et al., 1997). Transcribing the interviews and the verification process enabled me to begin to get to know the data. Thorne (2016) explained "knowing your data means dwelling in it repeatedly and purposefully and developing a relationship with it" (p.167). The data analysis involved multiple readings of the transcripts as well as listening to the audio-recordings and reviewing interview field notes.

Data collection and analysis proceeded in a concurrent and iterative fashion while comparing findings to the existing literature in order to locate "explanatory factors that might

arise from the analysis within the larger perspective" (Thorne et al., 2004, p.4). Some passages which were initially marked as important in early readings of the transcriptions later became less significant as more data was collected and later interviews are analyzed (Thorne, 2016). In re-reading earlier interview transcripts after later interviews, some passages that were not noted as significant at the first reading became more relevant for emerging themes (Thorne, 2016). Throughout the data analysis, I reminded myself to remain open to alternative interpretations and groupings of data as well as other interpretive possibilities as further data was collected (Thorne, 2016). This was particularly significant in going back to the first three interviews performed in January 2020 after completing the later interviews in July and September 2020, and reading through all six transcriptions once again while remaining open to new interpretations and groupings of data with the additional three interviews. In addition, analysis of earlier interviews helped to guide the addition of a question regarding how nurses establish a therapeutic relationship with a patient when a doula is present, as well as to seek clarification to explore emerging themes in subsequent interviews (Thorne, 2016).

I completed the following analysis steps after the first three interviews and again after all the interviews were completed. Also, when there was enough time between interviews, I read through the transcript and noted my initial impressions prior to the following interview in order to allow for seeking clarification in the subsequent interviews. First, I read through each transcript entirely and noted my initial impressions in the margins and highlighted significant the passages that related to the research question. Second, I re-read each transcript, reviewed the highlighted passages, read my initial impressions and made additional notes of recurring concepts on the blank page at the end of each transcript, similar to a concept map. Third, I reviewed the noted passages organized them by hand by transferring short descriptions and the

numbered lines of the associated quotations from the transcriptions onto “post-it” notes, then grouping the notes together in order to interpret the collected data and identify patterns. This led to the identification of common themes which were present throughout the data. Notes with brief theme and subtheme descriptions and associated transcription quotations were kept in word documents and edited throughout the analysis process. Handwritten drafts of concept maps linking themes and subthemes together were also kept with the printed transcripts. After analyzing all six interviews, I organized the identified themes and subthemes into a visual representation of the findings (see Figure 1 on page 73). These themes and subthemes were then verified for their ability to be applied back to the original individual cases (Thorne et al., 1997). I did this by reading through the transcripts once again alongside the visual representation of the findings and short descriptions of the themes and subthemes.

My thesis supervisor and thesis committee members were also involved in the data analysis process in order to minimize biased interpretations of the data (Polit & Beck, 2017). My thesis supervisor also read and re-read all six interview transcriptions. We met bi-weekly to discuss developments in the analysis. My other thesis committee members were also involved in the analysis. Graneheim and Lundman (2004) explained that there are multiple meanings contained within a text, and the reader’s “understanding is dependent on subjective interpretation” (p.106). Personal experiences can influence interpretation of the data (Graneheim & Lundman, 2004); therefore, it is beneficial to have several individuals with their unique life experiences interpreting the data to capture multiple meanings and a thorough understanding of the issue. Therefore, prior to the analysis discussion, each committee member was provided with an interview transcription and a copy of the visual representation of the findings. I then met with my thesis committee to discuss the data analysis. I presented the themes and subthemes as well

as the visual representation of the findings and made notes of the committee members' interpretive insights. Notes from meetings with the thesis committee were kept to be included in the audit trail along with the analysis notes and reflective journal.

Participant Characteristics

There were 84 registered nurses working at the initial study hospital birthing centre. Following the recruitment announcement and two email reminders sent to the nurses in this hospital birthing centre in December 2019 and January 2020, a total of four nurses contacted me by email to express their interest. After I responded to their initial email expressing interest to participate in an interview, three nurses followed-up and participated in an interview in January 2020. Four other nurses verbally expressed interest in providing a written response to questions when I presented the project on the unit, but they did not want to participate in an interview. A further five nurses from various hospital birthing units, across Ontario, contacted me to express their interest after the recruitment message was posted on the CAPWHN online forum in June, July and August 2020. Three of these nurses followed-up and participated in an interview in July and September 2020. A total of six registered nurses took part in individual interviews.

Between them, the six participants had experience working in nine different birthing units across Ontario, and one participant also had experience working in a birthing unit in British Columbia. These hospital birthing units included level one, level two and level three care facilities, as defined by the Provincial Council for Maternal and Child Health (2013). The definitions are available in Chapter One. The nurses' workplace hospital birthing units comprised local community hospitals, university affiliated hospitals and regional referral hospitals. The patient population served included low risk and high risk pregnancies. The nurse participants were experienced working alongside a variety of maternity healthcare providers in

each birthing unit, including registered practical nurses, midwives, family doctors, obstetricians, anesthesiologists, and pediatricians.

Table 3 summarizes the participant characteristics as reported at the time of data collection. Participants were asked if they had any additional training in the perinatal sphere in order to further understand their background and any additional training which could affect how they collaborate with doulas. One participant had pursued doula training to add to her labour support skills as an intrapartum nurse, as well as being an International Board Certified Lactation Consultant (IBCLC). Another participant was trained in the Billings Ovulation Method, a natural family planning method. One participant accumulated several specialized nursing certificates and additional perinatal training: breastfeeding certificate, nurse legal consultant, advanced certificate in perinatal nursing, advanced certificate in neonatal nursing, childbirth educator certificate, fetal health surveillance instructor, and Advances in Labour and Risk Management (ALARM) training.

Table 3

Participant Characteristics **(6)**

Characteristics	Number	Range
Mother tongue/First spoken language		
English	3	
French	3	
Born in Canada		
Yes	6	
No	0	
Highest level of education		
College diploma	1	
Bachelor's degree	5	
Years of nursing experience		
0-5 years	1	
6-10 years	2	4-35 Years
11-20 years	2	
> 21 years	1	
Estimated number of experiences working with doulas		
0-10 experiences	2	

11-15 experiences	1	10-30
16-20 experiences	1	Experiences
>21 experiences	2	
Self assessment of knowledge of the doula role		
I do not know about the role	0	
I know about the role a bit	2	
I know about the role well	3	
I know about the role very well	1	

Methodological Trustworthiness

Several methods were implemented to strengthen the credibility and trustworthiness of this study. Thorne (2016) has outlined several standards to strengthen credibility within ID research. These principles include *epistemological integrity*, *analytic logic*, *representative credibility*, and *interpretive authority* (Thorne, 2016).

Epistemological Integrity

Epistemological integrity refers to a tenable line of reasoning and consistency of theoretical allegiances about the nature of knowledge applied to the design and execution of the study and the decisions made throughout the research process (Thorne, 2016). The theoretical scaffolding, including the description of theoretical allegiances, literature review and personal reflection were key elements to enhance epistemological integrity. This set the stage for demonstrating how the theoretical scaffolding guided each step of the study. All modifications to the study design were explained and in line with the theoretical underpinnings of the study.

Representative Credibility

Representative credibility is determined by the researcher only making theoretical claims that are in line with the phenomenon under study and the manner and context in which it was sampled (Thorne, 2016). A clear description of the setting, context, participant selection criteria, data collection method and analytic process have been included in the dissemination of findings

as well as the inclusion of appropriate quotations, in order to support the transferability of the findings (Graneheim & Lundman, 2004). Representative credibility can be further evaluated by the reader in Chapter Four (Findings) through review of the analysis findings and the representative quotes provided while taking into account the information in the literature review regarding nurses and doulas working together, as well as the design of this study.

Analytic Logic

Analytic logic is demonstrated by making the researcher's reasoning explicit, from the theoretical scaffolding and continuously through to the interpretations of the research findings (Thorne, 2016). Thorne et al. (2004) explained that "the credibility of the findings will derive largely from the way the specific analytic decisions are presented and contextualized within the larger picture" (p.15). It is important to clearly document the researcher's way of thinking and account for their decision making throughout the research process.

A reflective journal was used to review my theoretical allegiances and reflect on how my experiences as both a nurse and a birth doula could affect my interpretations. This reflective journal was also used to keep field notes throughout the course of the study, including reflections after interviews, observations on participant's notable non-verbal behaviours, initial analysis impressions, and notes for future improvements to the interview guide. These notes were an integral part of the audit trail and documented the decision-making process throughout the study, such as the modification to the recruitment strategy and discussions of the data analysis. I also kept my notes from reading and re-reading the interview transcriptions which documented the progress of the data analysis.

Interpretive Authority

Interpretive authority refers to the need for "assurance that a researcher's interpretations are trustworthy, that they fairly illustrate or reveal some truth external to his or her own bias or experience" (Thorne, 2016, p.235). Investigator triangulation was used to ensure that several professionals and researchers in the perinatal nursing field with diverse backgrounds and experiences were involved in the analytical process and could discuss interpretations of the data (Graneheim & Lundman, 2004; Polit & Beck, 2012). Regular meetings were held with my thesis supervisor throughout the analytical process. Interpretations of the data were also discussed at a meeting with my thesis committee. Notes from this committee meeting were kept to be included in the audit trail. I also verified that the final themes and subthemes applied back to the original individual interview transcriptions (Thorne et al., 1997). Interpretive authority can be further evaluated by the reader by reviewing my reflection on my own bias and previous experiences as well as critically viewing the findings presented in Chapter Four (Findings) and the accompanying representative quotes.

Chapter Four – Findings

This chapter presents the interpretive findings that resulted from the data analysis. The following findings aim to answer the research question: How do nurses work in collaborative practice with doulas in the intrapartum hospital setting? A visual representation of the findings is included at the beginning of this section in order to guide the reader in locating each theme and sub-themes within the interpretive description findings and see how they relate to one another. Figure 1 illustrates a visual representation of the findings which emerged from the data analysis. This comprises the two main themes: first, the *Influences on nurses' readiness to collaborate with doulas;* and second, the *Continuum of nurse-doula collaboration*, each with four sub-themes. The two main themes are indicated in bold in Figure 1. Under the first theme, *Influences on nurses' readiness to collaborate with doulas*, the four sub-themes are *culture clash*, *support from management and hospital policies*, *previous professional experiences*, and *"it's about the patient"*. Under the second theme, *Continuum of nurse-doula collaboration*, the four sub-themes are *being open-minded*, *getting on the patient's team*, *building trust*, and *having the advantage of working together towards shared goals*. In the following sections, I describe each theme and sub-theme and provide supporting quotes from the interviews. Pseudonyms have been used when quoting participants.

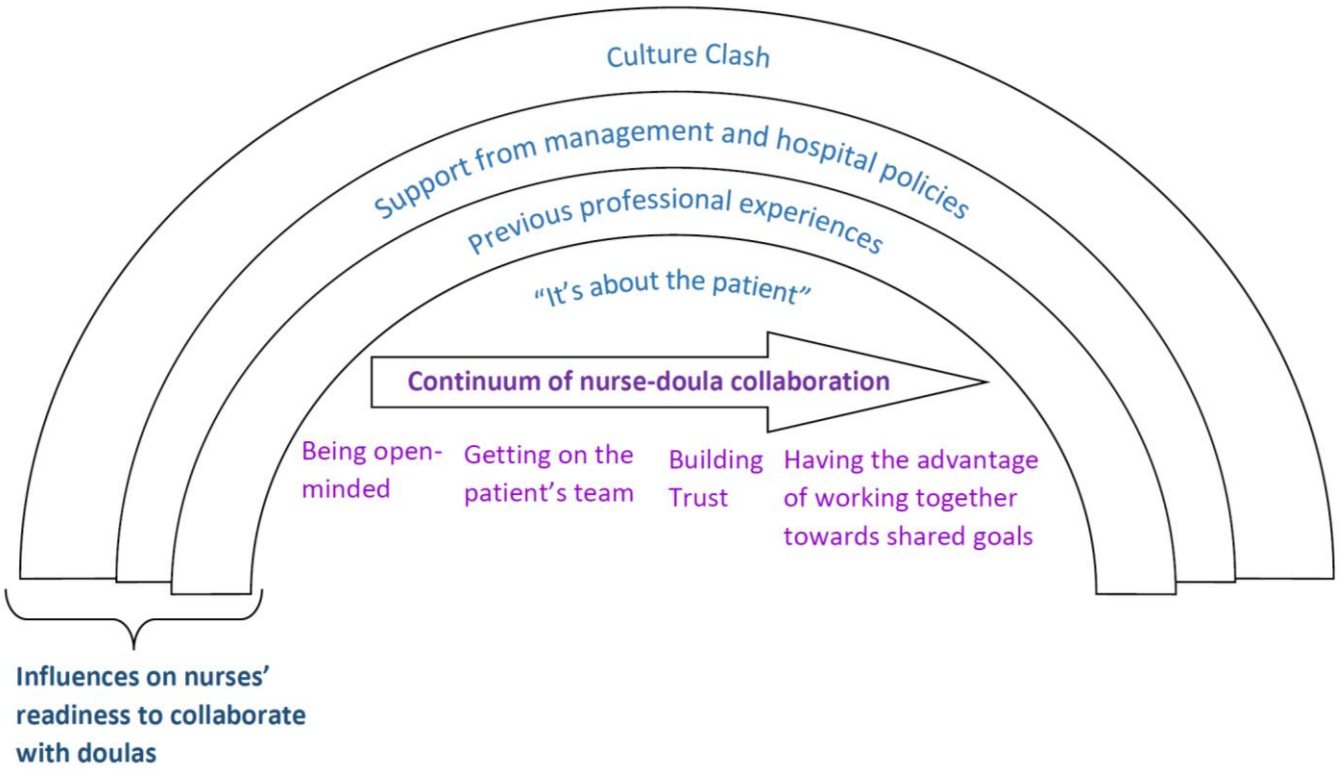
Influences on Nurses' Readiness to Collaborate with Doulas

Participants described the multiple levels of the influences on their readiness to collaborate with doulas. As illustrated in Figure 1, the influence at the level of society, the *culture clash* affects the individual hospitals and birthing units, as reflected in their *support from*

management and hospital policies. Additionally, this support from management and hospital policies influenced individual nurses in the form of *previous professional experiences*. All of

Figure 1

Visual Representation of How Intrapartum Nurses Collaborate with Doulas



these influences trickle down to the nurses' approach to care that *"it's about the patient"*. These influences, at the level of society, the hospital unit, the individual nurse and their approach to care, are represented as layers influencing the subsequent layers, working together to shape nurses' readiness to collaborate with doulas. These incorporate influences on the nurses' willingness to collaborate, as well as their ability and how well prepared they are to collaborate with doulas.

Culture Clash

At the societal level of influence, the outer arch in Figure 1, participants discussed the dichotomous natural birth culture and conventional medicine culture. The medicalized culture was characterized by a more pathological view and interventionist approach to birth while the natural culture aligned with viewing birth as a normal physiological process with intervention to be applied only as needed, trusting the birthing person's intuition and ability to birth their baby and seeing birth as a significant life event for the birthing person and their family. Participants explained that some nurses may hold attitudes towards birth that are more in line with the medicalized culture and see doulas as representing the more natural birth approach, thus positioning themselves in opposing camps instead of setting themselves up for collaboration. Armande said:

> Il y a bien des infirmières qui n'aiment même pas les sages-femmes. Ils n'aiment pas cette approche-là. Ils n'aiment pas l'approche douce. Ils n'aiment pas l'approche. C'est médical… C'est vraiment une grosse perception par rapport à toute la culture qui entrave l'accouchement plus naturel.

Participants explained that some nurses have pre-existing negative views of midwives, which they associate with the natural birth culture, and see doulas as also associated with this opposing culture, grouping doulas into their existing negative view of midwives even if they have not yet worked with a doula.

In addition, another nurse, Rhea, explained that there seems to be a shift towards the more natural birth culture in hospital birthing units' practices. However, she explained that some nurses are struggling with moving away from certain interventions that are more common in the dominant medicalized birth culture:

> [The culture has] been shifting more towards the more natural holistic. Birth doesn't have to be medicated. That being said, there are still those who are not quite there yet or who still see the value of those additional interventions because this is what they've practiced with over the years.

Support from Management and Hospital Policies

Participants described societal birth cultures being reflected in the hospital policies and support from management regarding collaboration with doulas. These can either be more or less favourable to collaboration. Policies which were described as facilitating nurses' collaboration with doulas are those that place importance on providing labour support, demonstrate an expectation of collaboration, and encourage seeing doulas as members of the interprofessional team. For example, nurses described nursing managers reinforcing that nurses are expected to be present in the room with the labouring patient and are trained to provide labour support as part of their nursing care responsibilities. Faye described the policies of her institution which facilitated collaboration with doulas:

> So the unit does have a policy that doulas are considered staff. So they come in and they do have the, like the right to accompany a patient to a c-section. They don't count as an extra person. The person, the patient is allowed one person in the room during her c-section, but doulas are an extra so if they have a doula, she's allowed to accompany them. She's allowed into say, our stockroom to go get a birthing ball and stuff like that. They're allowed to wear scrubs if they feel the need to for the delivery or things like that. So they are treated as per policy as team members which I think helps a lot.

As this nurse described, the policy of allowing doulas into the operating room as a second companion in addition to the partner highlights that doulas are not just another friend or family

member providing labour support; they are something different and are treated more like a member of the interprofessional team with whom nurses are expected to collaborate.

Conversely, participants noted there is a lack of training regarding the doula role, scope of practice and training, as well as how to effectively collaborate with doulas. Nessa described how she and her fellow nurses received training and guidance on how to work with other members of the interprofessional team, such as obstetricians, family doctors, pediatricians, anesthetists, social workers and spiritual care, but they did not receive any guidance on working with doulas:

> Unfortunately, we do not have any policies, nor have we any guidance on how to work with doulas…And it creates this idea, like I said, that they're not as important. So this is why we don't have them incorporated into our understanding of how to work with them.

A lack of policy, guidance from management and training about doulas can give nurses the impression that doulas are not important enough to learn about, so it is not important to work with them. The absence of clear information leaves nurses alone in a vacuum to make decisions about collaboration with doulas. In addition, nurses may be concerned about the limitations to apply in order to maintain their nursing standards of practice. Nurses need to know the activities that doulas can safely perform within the doulas' scope of practice and where these may overlap with intrapartum nursing responsibilities. They need to know how to safely navigate this overlap and whether they are responsible for overseeing any of the doulas' activities, as well as what they need to document in order to assure that they are fulfilling their institutional policies and following the appropriate professional nursing standards for their practice context.

Participants also noted that favourable hospital policies and positive messaging about doulas from management and healthcare professionals on the unit would be helpful to encourage greater collaboration with doulas. As Lucille explained:

> I think if there was more of an institutional, like a hospital established something, it would probably make doulas more respected or more valued in the hospital setting. So if like the hospital had a policy or the [obstetricians] acknowledged. I think that would help it more.

Previous Professional Experiences

Participants recounted various professional experiences that helped to shape their approach to care, including working with doulas. First, the participants explained that simply gaining more experience and seeing more women in labour helped them to appreciate women's non-pharmacologic labour support needs, that women need hands-on physical support as well as emotional support and encouragement throughout their labour. As Faye said, "I think the more labours you do, I think the more you see that women more than anything need support and need some stuff that they can't do themselves. They can't massage themselves. They can't do their own counterpressure." These experiences led them to value the labour support that women need and see the importance and the impact of this part of their nursing role. Participants expressed enjoying providing labour support, such as through advocacy and physical support. Two participants also noted acting as labour support person for their friends.

Second, participants discussed the impact of their initial training in intrapartum nursing as well as the influence of their preceptors' practices. Noelle, who had 35 years of nursing experience, recounted how she started her career in a low-intervention environment where she learned high touch care techniques from her nursing colleagues who were previously midwives

abroad. Another nurse, Nessa, conveyed the impact of a preceptor's practices on new intrapartum nurses and their future practice: "So it also has to do with the nurse that trains new hires, so you're trained a certain way. That's…kind of what that nurse continues with their practice." Noelle also reinforced this and explained further:

> You have to have an educator who has experience behind her in working with them [doulas], so that they can say that, you know, these are wonderful team members. They are part of our team, all right. They're not taking your place. They're part of our team that we're working together. And so it starts with the education of the nurse when she first comes in through an educator and then with her preceptors. The preceptors and also, the nurses themselves, they have to be aware that again, these doulas are part of our team, working as a team for this, this mother and her baby. So that's key. Absolutely key.

In this way, being trained by a preceptor who demonstrates a more physiologic holistic approach and willingness to work with doulas, someone who is a positive role model in providing labour support to mothers and collaborating with their doulas can help to facilitate their trainees' future practice regarding collaborative practice with doulas.

Third, participants discussed the influence of positive experiences with doulas. They spoke of seeing doulas actively supporting their clients, the techniques that they use, the impact of what they do and the trust and connection they have observed between doulas and their clients. As Lucille recounted:

> Like having some positive experiences where the doulas provided care I couldn't, or had that connection with the patient I didn't, and it benefited the patient a lot. That's pretty cool. I kind of thought like going into L&D that I would end up, I would be more holistic and like more like hands-on, but the reality is it's different. It's different than I initially

> thought, so I kind of respect that about doulas, that they're doing something I kind of thought maybe I would do more of.

Armande explained that her approach to working with doulas was greatly influenced by her first experience seeing a doula supporting her labouring client as well as the way they were able to work together:

> La première doula que j'ai travaillé avec à [hospital name] doit m'avoir très impressionnée parce que toutes ces techniques, tout qu'est-ce qu'on a fait, tout comment on a travaillé ensemble, puis les mouvements puis les positions qu'on a utilisées et tout ça.

This first positive experience let her see doulas as potential future collaborators and valuable assets with specialized skills to offer labouring patients.

These positive experiences also afforded nurses valuable opportunities to learn to work with doulas. Participants explained that since they did not receive any training about how to work with doulas, they learned on the job. As Lucille reported, "I think I've just kind of learned it like through experience." The participants also expressed that it could be difficult at first because they had no solid knowledge or training regarding the role and scope of doulas and how to collaborate with them, but it became easier with experience. Rhea explained:

> I think at the first time, I was maybe a little intimidated, and I had no idea. Like, what am I supposed to do? And then I just kind of like...Once I started getting to know who I was working with and getting a better idea, okay once I've had a doula the first time, 'okay, so that's what they do'. And then being able to like build on that…getting to appreciate their role more. And being able to say 'hey, this is how we can work together and make it easier for both of us.'

"It's About the Patient"

The participants' responses all revolved around the parturient patient. The patient was at the centre of their approach to care. The nurses described leaving their personal preferences aside, being non-judgemental and approaching every patient as a unique individual. They explained that the patient is the priority, and that nurses and doulas need to put aside any personal preferences or biases and work together to provide optimal care for their mutual patient. As Lucille expressed succinctly, "It has nothing to do with us. It's about the patient." Another nurse, Noelle, said, "the mother is the focal point, her and her baby…that's why we're here…It's them. It's not us. It's them. And understanding that the priority is them."

The nurses also wanted to know their patients' wishes and to do everything they could to contribute to the patients' positive experience in addition to optimal physical maternal and neonatal birth outcomes. Nessa explained, "Our fundamental goal here is for us to have the patient have a positive experience." Nurses were guided by asking themselves "What does she want?" and "How will she remember this?" Always bringing it back to the patient and making sure she did not get lost in the birth process. Nurses discussed ensuring the mother stayed informed of labour progress and involved in decision-making, keeping the mother at the center of their care. The participants discussed respecting their patients' choices, including the choice of having their doula present. Therefore, it was part of the nurses' job to work with this person that the patient had chosen to have present for support during their birth experience. As Noelle described, "I kind of went in with the fact of, you know, this mother has built this relationship with this, this doula, with this person. And she's, she's made the decision to have this person

there." Finding a way to work with the doula was a part of respecting the patient's choices and an essential part of embodying the approach that "it's about the patient".

Continuum of Nurse-Doula Collaboration

As seen in Figure 1, under the overarching *influences on nurses' readiness to collaborate with doulas*, participants described how they collaborate with doulas in the hospital setting along a continuum. Moving from left to right along the arrow illustrated in Figure 1, nurses entered the continuum with *being open-minded* which was necessary prior to engaging in *getting on the patient's team*, which then enables nurses to work on *building trust*, and finally the outcomes of the nurse-doula collaboration are defined within *having the advantage of working together towards shared goals*. Nurses could not enter this continuum without first *being open-minded*. They recounted experiences with doulas when they did not progress beyond this entry point in the continuum, as well as times when they progressed through the full continuum and enjoyed *having the advantage of working together towards shared goals*.

Being Open-Minded

Participants explained the importance of having an open mind and being open to working with others. This was discussed as a prerequisite to collaboration. Participants noted that one needs first to be open to the idea that doulas can be helpful before one can engage with the doula to collaborate. As Lucille explained:

> I think the biggest thing like on our end is being like open to them being there and being useful. So a lot of people don't see them as useful or see them as a hindrance to us just doing our job.

Participants discussed how false perceptions, prejudgements and assumptions can hinder collaboration. These could be on the part of the nurse, the doula or the patient, all of which

present a barrier to collaboration. On the part of the nurse, these false perceptions can stem from a lack of knowledge about the doula role, which can lead to misinterpreting actions and missed opportunities for collaboration, as one nurse described:

> Because [doulas] are very handy people to have around. And so if you don't know, kind of, what their role is and what they already have as experience then it's really…it's really kind of at a disadvantage for you because they can do a lot.

Furthermore, a nurse having the false perceptions that the doula will just get in their way presents an obstacle to collaboration to overcome even before they have met the patient and her doula. This can deprive the nurse of the opportunity to fully utilise the help of the doula and alleviate some of their workload. Armande noted this missed opportunity to help alleviate the nurse's workload was especially significant when the patient wanted a more natural birth experience:

> Parce que en réalité ces gens rendent notre vie très facile. Mais les gens, les infirmières, qui ont une mentalité plus fermée voient pas que cette personne-là elle va rendre ta vie très facile si ta mère en travail veut un accouchement naturel.

In addition, participants noted that sometimes patients come into the hospital thinking they will have to fight the system for what they want, and the nurse is seen as part of that system. Nurses described that some patients come in not trusting the hospital system and are apprehensive regarding the tendency to medicalize birth. These patients may bring their doula as a kind of protection or barrier between them and the hospital system. As Rhea described, "You have this impression sometimes that patients have it's an 'us vs them' mentality when they enter the hospital room, so the doula serves kind of like their protector against the healthcare system, for lack of a better word." Whether coming from the patient, the nurse or the doula, avoiding and

overcoming false perceptions, as well as keeping an open mind are essential to entering into the continuum of nurse-doula collaboration.

Participants also shared the common thread of being inquisitive. They described being open to new ideas and wanting to expand their knowledge as elements of being open-minded. They discussed the ways they strived to improve themselves and their nursing practice, questioning why things were done a certain way, always wanting to learn more, as well as engaging in reflective practice to identify how they could improve in the future after a difficult experience. For instance, they explained that although they had heard negative stories about doulas from colleagues, they remained open-minded and wanted to learn for themselves from working with doulas. One participant wanted to expand her knowledge of labour support techniques and had observed the techniques used by doulas, so she decided to pursue doula training. Participants also discussed questioning routine practices on their unit, such as routine insertion of a Foley urinary catheter after epidural initiation. They described looking to see what their unit protocol indicated as well as reviewing the evidence-based practice recommendations in the most recent literature. Furthermore, they acted to address any discrepancies between individual and unit practices or best evidence recommendations, by encouraging colleagues to follow the existing evidence-based protocol or working to change the unit protocol if it was not up to date with the latest evidence. These nurses wanted to ensure their patients were receiving the optimal quality care by keeping an open mind and continually working to improve their nursing practice.

Getting on the Patient's Team

Participants emphasized that the patient chooses who is a part of her support team. It is the patient's team. Participants talked about finding ways to join the patient's existing support

team, gaining the patient's trust and their willingness to have the nurse be part of her team. As Faye shared:

> Just putting a positive spin on really making sure that she knows that you're there to work with her and her doula. I feel like that makes it already like we're a team. And I feel like when, without a doula, you already have to be a team with your patient. So when she already is in a team with her doula, just tell her you want to join the team. That's it. Just, you know, you're not the outsider. You're not there just to monitor the baby. You're there to kind of be part of her journey.

The nurses discussed that it was important to them to form a connection with the patient, to quickly make that therapeutic connection. They were not just there to make sure the patient was safe, but also thrived on having a therapeutic relationship with the patient and being a part of her birth experience. Rhea explained that you cannot be a nurse at the bedside for so long and not thrive on connecting with patients, noting:

> So, I mean as much as, you know, we complain of working very hard, which we do, but it's fun to have, just to be part of that story. So when you have a doula there, it's great, she has another person that's there, and you can be part of the team that helps bring her child into the world. So that's really special. So we don't want to miss out either.

These nurses are happy to work with doulas as long as they are still able to *get on the patient's team*, as they would usually do when the patient is not accompanied by a doula. Rhea said, "As long as I'm able to establish a rapport and relationship with my patient, all is good."

Participants illustrated how they find different ways to provide labour support when a doula is already providing the hands-on support. They emphasized the importance of just being

present in the room, so that they can observe and also let the patient know that the nurse is there if needed. As Noelle described:

> I had to take that step back, but I was there and I stayed in the room even though the doula was there, so that mother knew. And it wasn't to watch the doula. I was there as a supportive person.

Mere presence, once the therapeutic relationship was established, was enough for nurses to feel that they were fulfilling their labour support role. Participants also described providing encouragement and emotional support, answering questions, keeping the patient informed of what is happening, and advocating for their patient with the rest of the healthcare team to listen to the patient's choices.

The participants further explained the strategies they used to get on the patient's team. Participants talked about following the existing "flow" by observing what is already happening in the room, asking questions and essentially following the patient's lead. Nessa described observing the dynamics in the room in order to identify where she could find her place on the team:

> I go by what the vibe is and what the emotions are in that room, and where I see my place in that space and how I can facilitate or may not facilitate. It's a challenge. I don't have a strategy. I just really go by what I feel.

Rhea noted:

> And sometimes you don't even need to have that conversation. You walk into a room and you see that they clearly have something going on, so you're like 'Okay, you keep doing that. That looks good.' I'll just [say] 'Hi, I'm your new nurse, keep doing what you're doing. You're doing great.' So you can kind of read a situation, see what's happening and

> then when there's a calmer moment, pull her [the doula] aside and be like 'is there anything you want me to do? Like can I help you in some way?'

With these actions, the nurse demonstrated her respect of the existing dynamics by quietly observing what was already happening in the room, quickly introducing herself, offering encouragement, and waiting for a calmer moment to ask questions and clarify how she could work within the existing dynamics.

In addition, participants explained that if you show the patient you are "on board" with her doula, if you show that you are ready to work with the doula, someone the patient already trusts, then you can piggyback on that established relationship to find your place in supporting the patient. As Armande described:

> Alors c'est un travail interné ensemble, so de cette façon, la patiente me fait confiance, je peux embarquer avec eux. So si la patiente voie que j'embarque dans les soins avec elle et sa doula, elle va me faire confiance puis elle va nous mettre ensemble dans le jeu.

Getting on the patient's team and forming that connection facilitates the nurse's ability to perform the tasks she needs to do to ensure the patient's and her baby's safety, such as taking a moment between contractions to do a fetal heart check, because the patient is more likely to work with you if you have gained her trust and you are "on her team". Armande further explained that by inquiring about the patient's choices and adapting care to work within her preferences, this facilitated getting on her team, and made it easier for the nurse to do her job:

> Je vois ça qu'ensemble si tu parles à la patiente, si tu rentres dans ce qu'elle veut, tu vas avoir pareille une relation thérapeutique avec elle, puis probablement encore mieux parce que toi tu vas être capable de faire tous ce que t'as à faire.

Participants also explained that the doula was a resource to gain insight into the patient's wishes which would then guide them in providing the best care for this individual patient. As Faye explained:

> I think my job is a lot easier for a patient who has a doula, because she's, like I said, she's already established a plan with her, they already have this bond going. And it's a lot easier for me to get an idea of what the patient wants, what to suggest and stuff like that.

Some participants explained that they would take a few minutes, when possible, to clarify the doula's role with this particular patient, what she does and doesn't do, and to clarify expectations about how they can best work together to support the patient in labour. This was also a chance for the nurse to gain information about the patient's preferences, such as her desired pain management methods. This discussion set the stage for the nurse-doula collaboration. The nurses noted that having this discussion to clarify preferences and expectations at the beginning of the nurse's shift could prevent later difficulties or conflicts.

In order to follow the existing dynamics and get on the patient's team, nurses need to be adaptable and flexible in their approach and how they perform their duties. Nurses described ensuring they perform their required assessments and responsibilities which are essential for patient safety while also being able to negotiate and adapt how they implement these for the individual patient and her expressed needs and choices. The participants noted that their ability to tailor their care became easier with experience.

In opposition to being flexible and adaptable, participants described territorialism and control as barriers to collaboration. Participants explained that doulas also need to be able to adapt and be flexible in their approach. Coming in with a set, unmovable plan was not helpful, as Noelle recounted:

> When it didn't go well was when the doula, when I would come into the room and the doula would immediately take over and said, 'I'm the doula. I am doing this. You're not going to interfere', you know. 'We are going to do this, and we will tell you what we want', sort of thing.

This lack of flexibility and demonstrated need for control does not facilitate collaborative practice. At times, doulas were perceived as territorial over their patients and as not making room for the nurse to connect with her patient or take part in labour support. In addition, participants noted that doulas need to be able to adapt to unexpected situations, be able to support their patient in these moments, and not get in the way of essential activities meant to ensure patient wellbeing.

Participants also discussed territorialism and control when asked how they think they are different from their colleagues and why they think some nurses have more difficulty working with doulas. They explained that some nurses may have more difficulty working with doulas if they are very set in their ways. They have their usual way of doing things and want everything to proceed according to their usual plan, so they have difficulty adapting their approach. Furthermore, participants described that some nurses may want to have more control over what is happening in "their" room with "their" patient, and don't like it when someone else, the doula, is making suggestions. As Armande reported, "parce qu'il y en a qui sont très contrôlantes de leur chambre, de leur patiente, le bébé, et tout ça." Faye gave the example that some nurses do not like coming back into the patient's room and finding their patient sitting on a birthing ball, and then coming in and finding her in the shower. They want to be more in control of the situation and do things their way. Therefore, they get irritated when the doula seemingly takes away some of their control of the situation and disrupts their routine. Moreover, some nurses

may be defensive and may not like that someone is encroaching on their territory, in that someone is taking over a part of the job that they usually do. As Faye shared:

> I know there are some nurses who love doulas because they feel like they do our job. And then there are the other nurses who don't like doulas because they don't like that they feel like they do our job.

The participants also noted that some nurses have trouble working with anyone else, not just doulas. Participants further suggested that some nurses just don't like having another person in the room and feeling like they are being watched as they go about their job. As Armande explained:

> C'est juste il y a quelqu'un dans leur chambre. Il y a quelqu'un, c'est comme une surveillance. Il y a des gens qui [n']aiment pas se faire voir faire, se faire voir travailler par quelqu'un d'autre. So il y a ça aussi, se faire regarder ou il y a quelqu'un dans leur territoire.

Working with a doula usually means lots of communication, one more person to keep in the loop and answering more questions. This can be perceived as adding to the nursing workload. Some nurses may not appreciate this additional work. On the other hand, for some nurses the doula's presence does not change their communication workload. One nurse mentioned that she already does a lot of patient teaching with everything she does, making sure the patient stays informed of what is going on, and suggested perhaps this is why she has never had an issue with doulas, because she already communicates a lot and has a similar approach to the doulas'.

Getting on the patient's team involves forming a connection, reading the room, and being flexible and adaptable. This ultimately makes it easier for the nurse to fulfill her role and is another step in the continuum of nurse-doula collaboration.

Building Trust

Participants discussed building trust with doulas through a mutual understanding of safety as the priority, assessment of the doula's competence, and familiarity with each other and the working environment. Participants described that even with the role overlap in providing labour support in the intrapartum setting, there is a difference in doulas and nurses' roles because the nurse is responsible for the patient and baby's safety and wellbeing. The participants explained that their main focus is on safety and they need to trust that the doula will not do anything to compromise the patient's safety. Participants described their assessment of a doula's competence as a key component of having trust in the doula. As Rhea explained:

> So if [the doula is] able to recognize what's normal and what's not. If you're able to support your client through that, that's great. But if you're like trying, still trying to go for non-interventionalist birth when clearly something is wrong, then no. Patient safety has to be first.

The participants explained that they need to know that the doula knows what is normal and what is not normal for labour, that the doula will not do anything or recommend something that could compromise patient safety, and that the doula will remain within her non-medical scope of practice. Doulas need to be able to support their clients through unexpected changes in labour and help their client work with the healthcare team to ensure their safety and wellbeing. Rhea gave the example of a fetal heart deceleration and how the nurse and doula can work together in this circumstance:

> I'm not asking [the doula] to step away. 'cause she should be with her patient, but I'm asking her to kind of like "okay, this is what's happening. This is why it's happening", if I'm not already doing that. Or if I am doing that, back me up, like "yes, we need to do

this for baby, so you can do this, so we're gonna do this way", like help her move into the position that we need to in order to get baby's…like if it's a decel or something.

The nurse didn't expect doulas to take a step back and abandon their client to the care of the healthcare team when medical intervention was needed, rather she expected them to reinforce and support the nurse when she explained to the patient what was happening and what needed to be done. The participants noted that doulas need to be able to emotionally support their clients though these difficult moments while also helping the healthcare team to proceed with what they need to do. The participants discussed needing to know that the doula will not contradict her and compromise trust between the nurse and the patient, since the doula is someone that the patient already trusts compared to a nurse that they have just met while in labour. This was identified as a possible source of conflict in the case of the doula contradicting and being perceived as fostering mistrust between the patient and healthcare team.

Negative experiences described by participants centered on a perceived lack of competence, described as doulas' suggestions or actions jeopardizing the patient's safety, as well as a lack of caring, conveyed as the nurses observing doulas not providing the expected one-to-one continuous support to the patient and essentially not fulfilling their labour support role and either physically or emotionally abandoning their client during her labour. A verbal conflict or a negative assessment of a doula's competence could negatively impact trust and potentially affect nurses' future readiness to collaborate with that doula, as Rhea explained: "Everybody knows who's competent and who isn't. So if you're a competent doula, you'll be fine."

In addition, participants reported that it is easier to work with and trust someone with whom they are familiar; someone with whom they have worked with before and know the way

they work, their background and their training. The participants explained that they are more familiar with their fellow nurses and other healthcare provider colleagues. As Rhea expressed:

> I guess it's just that I don't know them as well as I know my colleagues. Whereas my colleagues, okay I know like who they are. I know what they do. I know what they don't do. …So it's just the expectations are maybe clearer when it comes to when you're working with nursing colleagues versus when you're working with doulas. Just 'cause every doula is different.

They have clearer expectations of what their colleagues can and cannot do, as well as how they can collaborate. In contrast, they are less familiar with the doulas who come onto the birthing unit, possibly knowing only one or two by sight or by name. Faye described the impact on trust from being more familiar with a particular doula:

> I've had many experiences my last few with the same doula. And so you really get to know this particular person and their role with their patient. And I've gotten to also trust the doulas opinions a lot more on their client's needs and wants.

The participants also noted that it is helpful when doulas are familiar with the birthing unit's policies, protocols, and the materials that are available. By knowing these, the doula is less likely to suggest something that the nurse then has to contradict, which can be perceived as denying the patient something she wants. Such contradictions may compromise the patient's trust of the nurse, as well as compromise the nurse's trust of the doula.

Having the Advantage of Working Together Towards Shared Goals

Participants described wanting their patients to be able to look back positively on their birth experience; a goal they shared with the accompanying doulas and worked with the doulas

to achieve. Faye explained the positive outcomes of nurses and doulas working together towards shared goals:

> I feel like the more nurses can utilize their doulas and the more we can work together as a team, the better the outcome for the patient in both I find the 'le déroulement' [the unfolding] of the delivery, but also in the patient satisfaction of how her delivery went. And when she thinks back on it, she'll think, you know like I had this great doula that worked really well together with the nursing team, and everything just tied up the bow neatly.

Part of ensuring the patients' satisfaction with their birth experience was the patient's perception of the nurses' and doulas' ability to collaborate in caring for their patients throughout their labour. They cared how the patients would remember their birth experience, including the interactions between the nurse and the doula.

In addition, participants discussed appreciating each other's roles and strengths. They recognized the doulas' contribution to the smooth unfolding of the delivery and recognized that they have useful techniques and tricks both for comfort and to help labour progress. Participants described appreciating these different techniques, learning from the doulas from watching them in action and wanting to learn these from the doulas to use later with future patients. In Rhea's words:

> Just that like when [the doulas] have tips and tricks that I necessarily don't because I didn't do the doula course. So they have all these like cool tricks and I'm just like "hmm, I'm gonna steal that one day". So from that aspect it's very appreciated.

The nurses appreciated the specialized training the doulas brought to supporting their clients in labour and were able to provide labour support in other ways.

The participants highlighted that, during the intrapartum period, there is an overlap in the nurse's role and that of the doula in providing labour support. The nurses described the various ways that they navigate and appreciate this role overlap. As Faye explained:

> Some people feel I guess a little bit more threatened with doulas in the sense that like 'well she's doing all the massages and I don't get to do anything'. Whereas I look at it as 'great, if she's doing the massages, I can take the time to heat up the hot pack. I can get my room ready for the delivery or get caught up on my charting' and stuff like that. Or I can go help another patient who's having a delivery and make sure that nurse is well supported because she doesn't have a doula in her room and she doesn't have that extra help.

Some nurses took turns with doulas to provide hands-on support. When the unit was especially busy and the nurse had two patients, the patient having a doula could also liberate the nurse to spend more time with the second patient, and to help a nursing colleague who needed help during a delivery and did not have a doula in the room. Some nurses also explained that when they could, especially during a prolonged labour, they would offer the doula the opportunity to take a break while the nurse continued to provide labour support until her return, since the nurses realized that the doula did not have the same standard breaks as nurses usually do. This being another way to show appreciation for the sometimes very long continuous support aspect of the doula role and supporting each other as members of the mutual parturient patient's labour support team.

Participants explained that they have many responsibilities in caring for parturient women, so they appreciate when the doula can help them with one part of their workload. As Rhea shared:

> We have more hats, so it's nice to be able to have a hat to give to someone else. Like "here, you deal with this part, so that way I deal with everything else, and if you need help, I'm over here."

Nurses recounted that doulas were especially helpful when the unit was very busy or when they had two patients, but could not be in two places at once. It was reassuring to know that the doula was in the room with at least one of their patients, so the nurse knew that the patient had someone providing labour support when she could not be there. They explained it was like leaving a part of themselves in the room, and the nurse could trust that the doula would call them if they were needed.

Nurses and doulas work together to ensure that their mutual clients are well supported throughout their birth experience, whether this is done side by side by providing hands-on physical support or by the doula liberating the nurse of this hands-on support, so she can focus on other means of labour support and her many other responsibilities or even caring for other patients. Collaboratively and individually, they contribute to reaching their shared goal of providing optimal quality care for a smooth safe delivery and for the patient to have a positive birth experience.

Summary of the Findings

Participants' descriptions of their experiences working with doulas and how they developed skills in collaboration revealed the *Influences on nurses' readiness to collaborate with doulas* as well as the *Continuum of nurse-doula collaboration*. Together, these two themes form an interpretive description of how nurses work in collaborative practice with doulas in the intrapartum hospital setting.

The first main theme detailed influences on participants readiness to collaborate with doulas which included the societal level with the medical versus natural birth *culture clash*, the hospital/unit level regarding *support from management and hospital policies*, and the individual nurse level in their *previous professional experiences*, and the care approach that *"it's about the patient"*.

The second main theme laid out the progressive steps of nurse-doula collaboration along a continuum, which unfolds under the influences of the first theme. This continuum begins with the essential step of *being open-minded*, which includes nurses, doulas and their mutual clients not having false perceptions when entering into the interaction and nurses being inquisitive. Following *being open-minded*, participants described *getting on the patient's team*, finding their place within the existing support team and forming the sought-after therapeutic relationship with the patient. From here, participants discussed *building trust* and detailed the focus on safety and the features they perceive as characterizing the doula's competence that contribute to building trust, as well as explaining how familiarity can facilitate building trust. Finally, *having the advantage of working together towards shared goals* highlighted the outcomes of nurses and doulas collaborating in the intrapartum setting and how nurses navigate the overlapping labour support role shared with doulas during the intrapartum period. Participants' responses showed that they care about the patient's perception of her experience and therefore they strive to facilitate a positive experience, including how she will remember her nurse and doula working together.

In the next chapter, I will discuss how my findings relate and add to the existing literature on collaboration between nurses and doulas, as well as offer recommendations for nursing education, research, policy, and practice, and consider the strengths and limitations of this study.

Chapter Five – Discussion

This interpretive description (ID) study was led by the question, "How do nurses work in collaborative practice with doulas in the intrapartum hospital setting?" Previous research has explored the perspectives of healthcare providers (HCPs) on working with doulas; however, they have not specifically focussed on the nursing perspective (Akhavan & Lundgren, 2012; Klein et al., 2009; Lucas & Wright, 2019; Neel et al., 2019; Stevens et al., 2011). This study contributes new understanding regarding how nurses work in collaborative practice with doulas in the intrapartum hospital setting from the perspective of nurses. Through interviews with nurses experienced working with doulas in the hospital setting, several layered and interconnected *influences on nurses' readiness to work in collaborative practice with doulas* (as seen in Figure 1 on page 73) were identified. They further described how they work with doulas through a c*ontinuum of nurse-doula collaboration* under these influences when caring for patients accompanied by doulas.

In the following discussion, I will explain how my findings, presented in Chapter Four, contribute to the existing literature. I will elaborate on the *influences on nurses' readiness to collaborate with doulas* and review key elements of nursing presence that nurses integrate when caring for patients accompanied by doulas throughout the *continuum of nurse-doula collaboration*. Additionally, I will discuss the implications and recommendations for nursing education, practice, policy, and research, as well as review the strengths and limitations of this study. Note that throughout this chapter, "participants" refers to nurse participants in the present study.

Influences on Nurses' Readiness to Collaborate with Doulas

Once women enter the intrapartum hospital environment, they are under the influence of the institution's staffing and leadership structures, physical environment, and unit culture. They are also cared for by nurses who themselves are working under these influences and have personal preferences related to birth and labour pain management, as well as clinical training, knowledge and professional experiences that shape the care they provide to their labouring patients (Aschenbrenner et al., 2016; Hodnett et al., 2002; Klein et al., 2009; Liva et al., 2012; Lucas & Wright, 2019; Mackinnon et al., 2005; Payant et al., 2008; Roth et al, 2016; Ryan et al., 2010). The influences on nurses' readiness to collaborate with doulas as described by the nurse participants in this study are largely consistent with previous research on nurses' attitudes towards birth practices, including labour support and doulas, as well as the factors that influence these attitudes (Klein et al. 2009; Liva et al., 2012; Payant et al. 2008; Roth et al, 2016). These factors include workplace exposures, such as patient acuity and the level of care of the institution, the types of professionals with whom they work (e.g. exposure to more midwives or more obstetricians), the predominant birth culture on the unit, as well as perceived subjective and social norms set by their peers and managers (Klein et al. 2009; Liva et al., 2012; Lucas & Wright, 2019; Payant et al. 2008; Roth et al, 2016; Simmonds et al., 2013).

Liva et al. (2012) noted that workplace exposures to other healthcare providers' attitudes and practices could not only influence nurses' attitudes towards interventions, but also influence their attitudes towards doulas. Participants in the present study identified four key influences on their readiness to collaborate with doulas: societal birth cultures, hospital policies and support from managers, previous professional experiences, and having the approach to care that *"it's about the patient"*. These influences are consistent with the factors previously identified in the

literature. They represent interconnected layers of influence on nurses' readiness to work with doulas (as illustrated in Figure 1 on page 73), moving from the influence of societal birth cultures to the individual nurse's care approach, each layer exerting influence on the subsequent inner layer, as well as vice versa, since each layer is inextricably connected and present in all other layers of influence. As Simmonds et al. (2013) explained, "individual nurses and their settings are reciprocally and mutually defining in that hospitals and nurses shape the social and moral working environment within institutions" (p.149). Similarly, in this study, participants described the influence of societal birth cultures and these being reflected in the hospital policies and support from management regarding collaboration with doulas, as well as various professional experiences that helped to shape their approach to care. Together, these influences shape the social and perceived subjective norms which carry over into nurses' practice behaviours, including their readiness to collaborate with doulas (Payant et al., 2008; Simmonds et al., 2013).

Birth Cultures and Healthcare Providers' Attitudes in Intrapartum Care

Participants described the presence of the dichotomous natural birth culture and conventional medicalized birth culture. They explained that doulas are associated with the more natural birth culture, and therefore nurses who hold attitudes more in line with the medicalized culture and are more resistant to parting with certain routine interventions and may be less ready to collaborate with doulas. Following their study of HCPs' perceptions of working with doulas, Neel et al. (2019) suggested that the origin of conflict may lie in the culture clash between conventional medical culture characterized by a more pathological view of birth and interventionist approach and the more physiologic view of birth where appropriate interventions are applied as needed. This divide between birth cultures and their enacted approaches to

intrapartum care may become more evident with the presence of a doula, as the doula can represent the opposing culture in certain medicalized practice contexts. Simmonds et al. (2013) explained that nurses, birthing women, families and physicians come into the birth environment with their own understandings of birth that guide them in their care approach, how they set care priorities and how they respond to different expectations as labour unfolds. MacKinnon et al. (2005) observed that "tension occurs when nurses and physicians provide care not congruent with the needs and goals of the childbearing woman. Tension also occurs when the needs and priorities of the labour and delivery unit conflict with those of the woman and family members" (p.29). The doula's advocacy role inherently invites tension in circumstances where the nurses are charged with applying hospital policies and unit protocols more typical of the medicalized institutional birth environment (Neel et al., 2019). Neel et al. (2019) explained, "because many doulas are hired to protect the patient experience, they can erroneously come to represent the source of conflict" (p.5-6). The doula, having the responsibility of supporting her client to advocate for her client's preferences, can further amplify the cultural tension and lead to the oversimplified conclusion that the doula's presence is the source of conflict. This tension exists even when a doula is not present (Neel et al., 2019), but the doula can come to represent the source of this tension. In the present study, one participant noted that perhaps she had never had a negative experience with a doula because she has a similar view of birth and approach to care (even though she worked in a highly medicalized tertiary center). Zielinski et al. (2016) observed that "ideally maternity care providers [would] have congruent approaches to labour and birth practices so that they can work together to honour women's choices within the context of safe and satisfying birth" (p.113).

Several participants in this study also noted that some patients seem to bring their doula with them to protect them from the hospital system and unnecessary interventions, coming in with an "us vs. them" mentality. This demonstrates how some patients already have a mistrust of the healthcare team, including the nurses. They assume that they will have to push back against the medicalized birth culture, further emphasizing the attitudinal divide and enlisting the doula as an advocate and mediator. This places doulas in a position to become the focal point of any conflicts between hospital practice or HCP recommendations and the patient's preference for a more physiologic approach. Similarly, Lothian (2006) proposed that birth plans can lead to tension when patients and HCPs have opposing views of birth, either as a normal physiologic process or as pathological and necessitating routine interventions to reduce adverse outcomes.

Additionally, several participants recounted feeling offended that patients assumed they would have to fight for what they wanted and that somehow the nurses were not going to follow their stated preferences or that they were not acting in their patients' best interest. In this case, the doula being present as the protector fed into the feeling of offence because the nurse shared the physiologic view of birth but the patient and family assumed otherwise, so the nurse was denied their patient's trust from the onset of the interaction. This adds to Neel et al.'s (2019) observation that some HCPs viewed doulas as an indication of patients' disappointment with hospital care.

Insights from the nurses interviewed in this study illustrate the birth culture clash as evidenced by the discordance between the lower intervention physiologic approach that some patients seek and the realities of the medicalized hospital environment as well as the attitudes and beliefs held by their assigned intrapartum nurses. These findings address several questions asked by Papagni and Buckner (2006) following their study on nurses' attitudes towards doulas

from patients' perspectives: (a) "Are [nurses] so accustomed to medicalized birth that they are unable or unwilling to adapt to an alternative support person?" (p.17); (b) Are nurses "resentful because of the presence of a doula or because the mother chose to give birth naturally without many of the interventions provided to most patients?" (p.17). These questions are further explored in later sections of this chapter on challenges to implementing patient-centered care and establishing therapeutic relationships.

Influence of Nursing Leaders

Participants described the influence of nursing leaders in setting expectations regarding nurses' practice behaviours. This included having clear guidance or perceiving that management expected nurses to collaborate with doulas and treat them as members of the care team. In Social Identity Theory, Tajfel and Turner (1979) explained that individuals define appropriate behaviour by looking to the norms of the groups to which they belong. Therefore, if collaboration is the social norm, nurses of a unit are more likely to act this way if they have a sense of belonging to their unit nurses' group as well as identify as members of the labour support team with doulas. Participants also noted that being trained to provide labour support as well as nursing leaders communicating the expectation that being present with the labouring patient and provide support are priority nursing responsibilities were important. Payant et al. (2008) discussed the influence of perceived subjective norms on nurses' intentions to provide labour support. These norms include the perceived expectations from nursing colleagues, other healthcare providers and managers (Graham et al., 2004; Hodnett et al., 2002; MacKinnon et al., 2005; Payant et al., 2008). Other authors have highlighted that nurse leaders' behaviours can influence staff nurses' actions (O'Donnell et al., 2012; Udod & Wagner, 2018), thus noting the influence not only of nursing managers, but of other nursing leaders in the practice setting.

Nursing leaders, such as care facilitators and nurse educators, are in an optimal position to act as role models, change agents and change coaches (Sullivan, 2013; Ryan et al., 2010; Udod & Wagner; 2018). A change agent is typically someone in a position with either formal or informal power, who helps to guide and plan the desired change, and acts as a role model for other nurses and members of the healthcare team (Sullivan, 2013; Udod & Wagner; 2018). A nurse leader can act as a change coach by using guidance, inspiration and facilitation to set expectations for staff nurses' behaviours, such as the managers who encouraged and facilitated the nurse participants to provide labour support and work in collaborative practice with doulas (Stefancyk et al., 2013; Udod & Wagner, 2018). These nursing leaders are in an optimal position to influence the culture of care of their unit and prioritize the implementation of evidence-based policies that facilitate collaboration with doulas

Influence of Initial Training and Preceptors on Future Practice

Participants described the impact of their initial training in intrapartum nursing as well as the influence of preceptors on future nursing practice. They illustrated how the initial intrapartum nursing training environment can set the stage for nurses' views of birth, what is normal expected practice and the skills and competencies that are most valued and prioritized in the nursing care for labouring women. Participants also conveyed the impact of a preceptor's practices on new intrapartum nurses and their future practice. They explained that when nurses are initially trained a certain way, they tend to continue to work that way. This not only applied to skills in providing efficient care, but also in learning a holistic physiologic approach and learning to see doulas as team members who are not there to replace you, but who are there to be an ally and a resource to provide optimal care to labouring patients. Simmonds et al. (2013) explained that "novice nurses learned what to expect from their mentors, who established

cultural and practice norms for new nurses" (p.154). Mentoring includes preceptorship, role modeling and coaching (Ryan et al., 2010). Although the role of preceptors and mentors has not previously been described in relation to nurses' attitudes or readiness to collaborate with doulas, this finding is consistent with previous research regarding the broader role of preceptors and mentors in intrapartum nursing.

Similar to the findings of Ryan et al. (2010) regarding the influence of mentoring as relational learning in perinatal nursing, the findings from this study demonstrate the importance of carefully planning intrapartum nurses' initial orientation training. New nurses take in the unit's birth culture and its associated practices, that are reflected and prioritized in the training, as well as the guidance they receive from nurse leaders. This can be in the form of allocating adequate time to develop labour support skills and selecting the most appropriate staff nurses to be effective facilitating influences as preceptors for new nurses. In 2001, Kardon-Edgren wrote that there was a generation of nurses who had come into practice only knowing highly technological birth and might not be prepared to provide labour support. It is worth considering that some of these once novice nurses who completed their influential initial training in a highly technological environment are now the experienced nurses on their units, the managers, potential preceptors and mentors for the subsequent generations of nurses.

Preceptors facilitate learning as clinical teachers and role models, serving as experts to promote evidence-based practice (Bott et al., 2011; Moore & Cagle, 2012; Powers et al. 2019). They help nurses to translate their theoretical knowledge into nursing practice (Powers et al. 2019; Ryan et al., 2010). This learning goes beyond the clinical skills of intrapartum nursing to appreciating connecting with parturient patients and their families as integral to the intrapartum nursing role (Ryan et al., 2010). Preceptors role-model the "intimacy of the relationship between

the [intrapartum] nurse and the birthing woman through presence, conversation and touch" (Ryan et al., 2010, p.187). This role-modelling by the preceptor contributes to nurses' understanding of what is expected of them. Furthermore, as novice nurses mirror this engagement with labouring patients and their families, as well as engage with their colleagues, they continue to learn and develop their professional nursing practice (Ryan et al., 2010). Being guided by mentors who demonstrate a more physiologic holistic patient-centered approach, who are positive role models for providing labour support to mothers and who engage in collaboration with doulas can help to facilitate novice nurses' future readiness to collaborate with doulas.

Person, family, patient-centered care

Nurses' responses in this study reflected their *"It's about the patient"* approach to care. This was characterised by seeing every parturient under their care as a unique individual with their unique histories, circumstances, and their own preferences, wishes, and values that were deserving of their respect. So even if they did not agree with a patient's choices, it was the nurses' job to put their own preferences aside and provide non-judgemental respectful individualised care.

Though many terms have been utilised for patient-centered care, the characteristics of *Person- and Family-Centred Care* from the Registered Nurses Association of Ontario's (RNAO) Best Practice Guideline describes many of the same core principles expressed by the nurses interviewed for this study. Person-centered care focusses on the individual as a whole person with unique needs, values, preferences, and experiences (Registered Nurses Association of Ontario, 2015). The nurses' responsibility is to establish a therapeutic relationship with the patient and open communication to discover the individual's definition of health and their preferences (Registered Nurses Association of Ontario, 2015). Nurses give information and

discuss options to facilitate informed decision-making, subsequently creating a plan of care that is agreeable to the individual and respect and communicate these preferences to the healthcare team (Registered Nurses Association of Ontario, 2015). This process involves being flexible in the way care is provided and engaging the patient in the planning of their care (Registered Nurses Association of Ontario, 2015). This is also consistent with the Association of Women's Health, Obstetric and Neonatal Nurses' (2011) description of patient-centered care in their publication, *Quality Patient Care in Labor and Delivery: A Call to Action*. The authors of the call to action stated, "mutual respect, patient-centered care, and shared decision making are essential for providing quality obstetric care" (Association of Women's Health, Obstetric and Neonatal Nurses, 2011, p. 152). They define patient-centered care as HCPs and the system within which they work accepting that "values, culture, choices, and preferences of a woman and her family are relevant within the context of promoting optimal health outcomes. The overarching principles include treating childbearing women with kindness, respect, dignity, and cultural sensitivity, throughout their maternity care experiences" (Association of Women's Health, Obstetric and Neonatal Nurses, 2011, p. 151).

Simmonds et al. (2013) observed that respecting and supporting women's choices has habitually been acknowledged as an essential nursing moral responsibility. Nursing care responsibilities go beyond promoting safety and emotional support, but also involve facilitating informed decision making and providing respectful care (Canadian Nurses Association, 2017; Simmonds et al., 2013). Shared decision making is a process by which the patient becomes fully informed of the available options and through which they become fully informed of the best available evidence in order to come to a decision that is congruent with their values and preferences (Charles et al., 1997; Simmonds et al., 2013; Villarmea & Kelly, 2020). It is

important to keep in mind that the patient's definition and understanding of "health" is unique to them and may differ from the HCPs around them. Furthermore, the final decision belongs to the patient and does not have to be approved by the healthcare team (Villarmea & Kelly, 2020). In the context of working with patients accompanied by their doulas, the participants in this study continued to embody their patient-centered approach by demonstrating respect for their patients' choice to have a doula to support them in labour and by working with the doulas as members of their patients' support team.

Just as HCPs and patients may have different definitions of "health", HCPs, doulas and patient may have different ideas of what constitutes patient-centered care or quality obstetrical care. In the following sections, I will discuss how the shared understandings of patient-centered care and shared goals can facilitate collaboration and the significance of the birth experience as an underlying rationale for collaborating with doulas. I will also review the challenges to patient-centered care and how doulas facilitate nurses' patient-centered approach in intrapartum hospital setting.

Shared understandings and goals. The *"It's about the patient"* approach encompasses values and attitudes that form nurses' approach in caring for their labouring patients. Different interpretations and understandings of what constitutes patient-centered care or best care, as well as each team member's responsibilities can lead to loss of trust and feelings of resentment (Simmonds et al., 2013; Zielinski et al., 2016). Recall that these study findings indicate that nurses' *"it's about the patient"* approach is formed by the outer layers of influence (as illustrated in Figure 1 on page 73). Nurses' understanding of patient-centered care may differ from other HCPs around them as well as the doulas they encounter. Zielinski et al. (2016) stated, "although common goals seem to exist, incongruities between stated goals and actual birth practices are

common" (p.282). Since doulas are not habitually members of an established intrapartum team, participants described that it is important to clarify roles and expectations as soon as possible to facilitate collaboration and avoid misunderstandings at a later time. Guided by a shared understanding of patient-centered care, nurses are better prepared to enter the *continuum of nurse-doula collaboration* to work in collaborative practice with doulas towards the goals of providing optimal quality care for a smooth safe delivery and for the patient to have a positive birth experience. In this way, shared common goals can mitigate the possible territorialism and ease the navigation of their role overlap in providing labour support. Nurses and doulas can see themselves as members of the patient's support team rather than two separate groups, "nurses" and "doulas", each having unique skills to offer, each fulfilling their responsibilities and following their scope of practice to best support their mutual patients.

Recognizing the impact of the birth experience. Simkin (1996) encouraged HCPs to consider that

> there is much more involved in the outcomes of 'a healthy mother and a healthy baby' than coming out alive with no permanent physical damage. The potential for psychological benefits or damage is present at every birth. In addition to a safe outcome, the goal of a good memory should guide the caregiver. (p.252)

Although safety was noted as a priority by the nurse participants, they voiced that their goal was not only to ensure a safe outcome for their patient; their goal was also to ensure the best possible birth experience. Their responses reflected an understanding that birth is not just another day in women's lives (Simkin 1991; Simkin 1992). They described it as a significant experience with the potential to impact how they interacted with their baby after the birth and highlighted the importance of how their patients would look back on their birth experience in years to come,

including the memory of how the nursing staff and their doula worked together to support them in labour.

Many researchers have explored the potential impact of the birth experience. Birth is not just another day in women's lives. Simkin (1992) explained, "birth memories remain alive on a cognitive and psychological level and continue to influence the woman's perceptions even long after her baby is born" (p.81). This unique experience and the memory created are powerful and have the potential to either positively or negatively impact the way in which mothers see themselves, how they feel as a mother to their child, and their wellbeing (Ayers et al., 2016; Simkin 1991; Simkin, 1992; Simkin 1996; Reed et al., 2017). Papagni and Buckner (2006) reported that conflict between nurses and doulas can negatively influence the birth experience; whereas continuous labour support (CLS) provided by doulas usually leads to more positive birth experiences (Bohren et al., 2017). Furthermore, women remember vividly how they were treated in labour and whether their caregivers were supportive of their choices or not (Lunda et al., 2018; Simkin, 1991; Simkin, 1992; Papagni & Buckner, 2006). Women's positive birth experiences are facilitated when nurses provide care with kindness and empathy, when nurses see their patients as unique individuals and respect their right to be involved in decision-making for their care and advocate for their choices to be heard and upheld (Hallgren et al., 2005; Lunda et al., 2018; McKinnon et al., 2003; Simmonds et al., 2013, Reed et al., 2017). Nurses need to consider that even when the outcome is not what was expected, women are more likely to reflect positively on their birth experience if they were cared for as an individual with respect and were actively involved in decision-making (Villarmea & Kelly, 2020). Safety is the priority, but nurses' goal in patient-centered care is not only for patients to survive. They want their patients to thrive.

Challenges to patient-centered care in the intrapartum hospital setting. Participants described several challenges to fully and consistently implementing a patient-centered care approach in the intrapartum hospital setting, as previously documented in the existing literature. Ryan et al. (2010) asserted that "nurses' woman-centered philosophy is challenged in current institutionalized birth environments" (p.187). Nurses are under the influence of their institutional environment in which birth is largely medicalized and dominated by "routine care" (MacKinnon et al., 2005). In this environment, Papagni and Buckner (2009) asked "Are [nurses] so accustomed to medicalized birth that they are unable or unwilling to adapt to an alternative support person?" (p.17). Nurses are tasked with navigating an incongruous system where unit protocols and routines are expected to be implemented for all labouring women while at the same time being expected to view every patient as a unique individual, requiring them to tailor their care to meet each patient's unique needs and preferences (MacKinnon et al., 2005). Some nurses, such as those who shared their stories in this study, are better able to be flexible and adapt to their individual patients' preferences even within their institutional environment. This made them adept at working with patients accompanied by doulas. However, other nurses may have more difficulty adapting to patient preferences in their institutional context due to their attitudes towards certain birth practices and their need to be more in control of the birthing environment, as described by the participants and in previous studies (Aschenbrenner et al., 2016; Klein et al, 2009; Liva et al., 2012; Simmonds et al., 2013; Payant et al., 2008). This is also consistent with Ryan et al.'s (2010) observation that even though nurses understood the expectation to listen to the patient's preferences and tailor care to respect their wishes, this is not always implemented in practice. MacKinnon et al. (2005) also reported "dissonance exists between the philosophic and theoretic claims of the profession in relation to nursing care,

nursing practice, and the day-to-day lived realities of nurses and the women who labour with them" (MacKinnon et al., 2005, p.29). Additionally, nurses often have to cope with understaffing and the acuity of the unit which reduces the time they have to establish therapeutic relationships, discover their patients' preferences and tailor care to match these (Ryan et al., 2010).

Nursing Presence – Key Elements of the Continuum of Nurse-Doula Collaboration

Childbearing women have previously recounted the meaning of nurses' presence in intrapartum care. Nursing presence has been summarized as "being there (physical presence), being with (emotional support), and being for (advocacy)" (MacKinnon et al., 2005, p.34). Nursing presence has been described as an essential nursing competency by nursing mentors (Ryan et al., 2010). Mentors consider their mentees are "becoming" perinatal nurses when they are able to integrate these elements of nursing presence into their interactions with labouring women while they perform their other nursing responsibilities and clinical skills, such as inserting an intravenous or correctly following and adjusting intrapartum care protocols (Ryan et al., 2010). In the following section, I will explore key elements of nursing presence and patient-centered nursing practice that participants illustrated as an integral part of how they navigate through the *continuum of nurse-doula collaboration*.

Physical presence. Participants reported that although they valued and enjoyed giving hands-on labour support, they could be satisfied to provide labour support by simply being present in the room as long as they had the opportunity to establish a therapeutic relationship with their patient. This way, the nurse respected the existing dynamics of the room, knowing the doula and other support team members could continue to provide hands-on labour support to the patient needed while the nurse was occupied with other activities in the labour rooms. The patient could see that the nurse was there in case they were needed and could observe the

progress of labour and step in to offer hands-on support as needed (Adams & Bianchi, 2008, Lunda et al., 2018).

Participants in the present study shared feeling reassured by knowing that the doula could be present with their patient even when the nurse could not be in the room. Although they knew that the doula was not a medical professional, they felt reassured that if something was truly wrong, the doula could raise the alarm as well as continue to provide CLS. Birthing women also expect to have a continuous presence during their labour and the negative impact of nurses' absence during labour has been documented (Lunda et al., 2018; MacKinnon et al., 2005). The doula's presence could be considered to increase satisfaction with care for the nurse and the patient especially when the unit is busy or understaffed.

Even when the nurse could be present in the room, participants described that it was nice to be able to share one of their responsibilities, labour support, with the doula because nurses have many other things to do even when they are providing one-to-one nursing care. Nurses' other technical and legal responsibilities, such as extensive charting and management of technologies can interfere with their ability to meet women's labour support needs and expectations (MacKinnon et al., 2005; Payant et al., 2008). It is important to keep in mind that CLS provided by doulas does not replace the labour support provided by nurses, and even when accompanied by their doulas, women still want to connect with their nurses and have their support (Gilliland, 2011; Lunda et al., 2018).

Establishing therapeutic relationships. Establishing therapeutic relationships with birthing persons is a key feature of nursing presence and patient-centered care. This was further described by participants in the *continuum of nurse-doula collaboration* and has been discussed in previous intrapartum research findings. Simmonds et al. (2013) stated, "the establishment of

effective relationships with childbearing women in which plans for birth are mutually negotiated is fundamental to good intrapartum nursing practice" (p.148). MacKinnon et al. (2005) noted that skillful intrapartum nursing necessitates both knowledge of best practices and knowing the birthing person's individual preferences and fears, so they can provide care accordingly.

Participants in this study revealed how they established this therapeutic connection with their patients when they are accompanied by their doulas. They described many of the verbal and non-verbal characteristics needed to engage authentically and quickly establish trusting nurse-patient relationships. They recounted going into the birthing room with an open mind, without prejudgements, leaving their preferences aside to provide non-judgmental care, paying attention to the existing dynamics in the room and respecting the patient's existing relationships with the people in the room, including the patient's doula. These strategies are echoed in the literature on nursing presence and engaging authentically with patients in the intrapartum setting (Association of Women's Health, Obstetric and Neonatal Nurses, 2011; Adams & Bianchi, 2008; MacKinnon et al., 2005; Pratt et al., 2021; Registered Nurses Association of Ontario, 2015). These features, as described by the nurses in this study, are consistent with those described by Adams & Bianchi (2008): "being open, honest, and non-judgemental with the client, listening intently to her needs and concerns; understanding the privilege of being part of the client's life" (p.109).

In addition, nurses recounted being unobtrusive when entering the room, respecting the labouring person's need to focus on coping during contractions, quietly introducing themselves and getting to know the support team members already in the room. This opened communication and allowed the nurses to then explain their role as well as get to know the patient's wishes either from the birthing person directly or by turning to the doula to learn more about what had been discussed prenatally. This study's findings also illuminated that nurses found doulas to be a

helpful resource to gain further information about their patients' wishes when women are focussed on coping in labour, thereby enhancing nurses' ability to advocate for their patient's choices and facilitating establishing therapeutic relationships. The methods described by participants incorporated conveying respect, empathy, caring, trustworthiness and competence (Association of Women's Health, Obstetric and Neonatal Nurses, 2011; Adams & Bianchi, 2008; Pratt et al., 2021; Registered Nurses Association of Ontario, 2015), and demonstrated to the patients that their nurses acknowledged each of them as unique individuals with their own values, beliefs and preferences. Adams and Bianchi (2008) observed, "communicating caring, competence, and advocacy early in the nurse-client relationship fosters the development of a trusting relationship through which emotional and physical needs can be met" (p.109).

Additionally, Pratt et al. (2021) and Goldberg (2005) affirmed that the patient's first impression of the nurse can have a great impact on the establishment of the therapeutic relationship. Therefore, if the nurse demonstrates openness and respect for the doula, someone the birthing person has chosen to have with them during this significant experience and that they already trust, then the patient may be more likely to be open to connecting with the nurse and welcoming her onto her support team. In this way, the findings from this thesis research contribute further insight by describing how nurses build on the existing trusting relationship between the patient and the doula by observing the existing dynamics in the room, as well as demonstrating respect for the birthing person's choice to have a doula and showing a willingness to be flexible and adaptable in how they provide care to work within the birthing person's preferences. Once this connection was established, participants described that it was then easier for them to fulfill their other nursing responsibilities. Simmonds et al. (2013) similarly described how nurses responded to birthing women's expectations and negotiated care by offering women

options from which they could choose freely and still "[allowed] the nurse to 'do what she [needed] to do'" (p.153).

These study findings reiterate that intrapartum nurses value establishing a therapeutic relationship with their birthing patients and this connection contributes not only to their patients' satisfaction with care, but the nurses' job satisfaction as well (Lunda et al., 2018; MacKinnon et al., 2005; Pratt et al., 2021). Goldberg (2005) explained that the relationship between birthing women and nurses is "…unique. In a short period of time an engagement occurs that unites the two together in an embodied experience that ends with a remarkable journey: the birth of a baby" (p.401). However, even though nurses value this therapeutic relationship, institutional factors, such as understaffing, high patient quotas, and the practice context placing higher value on other aspects of nursing care can make it difficult to sustain these (Simmonds et al., 2013). Nurses described feeling concerned for their patients' wellbeing when they could not be present to provide the care they believed the patient deserved and desired and when they thought the patient's positive birth experience was threatened. Previous studies have also reported nurses counting a positive birth experience as a part of optimal outcomes (Simmonds et al., 2013; Simpson & Lyndon, 2017).

Advocacy. Advocacy is an important nursing responsibility as well as being a component of labour support and nursing presence (Adams & Bianchi 2008; MacKinnon et al., 2005; Pratt et al., 2021). Nurses can support patient's wishes through their words and actions, and by communicating these wishes and negotiating with other members of the healthcare team on the birthing person's behalf (Adams & Bianchi, 2008). Doulas are also nurses' allies in helping them fulfil their advocacy role. Doulas can encourage the birthing person to voice their wishes and can

be seen as a reminder for the nurses to view the whole unique individual and their preferences, especially when working in a more challenging medicalized institutional birth setting.

Participants related that patient safety was their priority and explained that it was important for *building trust* that the nurses understood the doula would not do or suggest anything that would compromise patient safety. They also noted that it was important for doulas not to contradict them when they were explaining something to the patient. This relates to previous findings in the literature that the informational support and advocacy role of doulas are potential sources of conflict between HCPs and doulas (Amram et al., 2014; Eftekhary et al., 2010; Neel et al., 2019). Giving information can be perceived by HCPs as fostering mistrust, especially when the information contradicts what the HCP has said or implies that the HCP is not sharing complete information or giving information that is not evidence-based (Amram et al., 2014; Eftekhary et al., 2010; Neel et al., 2019).

Participants' responses also suggest that doulas' advocacy and informational support roles may be challenging for *building trust* when doulas are charged with advocating for their patients' choices which are considered as compromising safety in the eyes of the nurses. Although this is within their scope, as previously noted, the patients' choices may be mistakenly attributed to the doulas' influence. This also relates to the influence of the *culture clash* sub-theme because from a more medicalized view, an intervention may be considered to enhance safety by some nurses, but the patient may not share this view and may choose to reject the suggested intervention. While nurses described a patient-centered care approach which included respecting the patient's choices, they appear to echo the moral phenomenon reported by Simmonds et al. (2013) where "nurses were willing to advocate for women's choices within the parameters of safety…[and] values such as natural childbirth were sidelined when the well-being

of mother and baby was thought to be at risk" (p.152). Nurses can be in a difficult position where they perceive their dual responsibility of ensuring patients' safety and advocating for patients' choices are at odds and the doula's advocacy role may add additional pressure. There is a need to further clarify the informational support and advocacy roles of nurses and doulas to develop strategies that will further facilitate collaboration between nurses and doulas, particularly in situations when nurses perceive patient safety is at risk.

Returning to Papagni and Buckner's (2006) question, "Do nurses feel their role is threatened by the presence of a doula?" (p.17); the respondents in this study found most doulas helpful and were reassured by their presence. The overlap in their labour support roles was not threatening, rather it was helpful and enhanced their practice, although this was contingent on their continued ability to establish a therapeutic relationship with their patient (*getting on the patient's team*). Nurses who feel more territorial over their patients or have pre-existing negative assumptions about doulas may feel more threatened by the presence of a doula. Participants further explained that when they did not progress beyond *being open-minded*, they did not have the same satisfaction from engaging with the patient and her support team, but they continued to integrate many elements of nursing presence and the non-judgemental patient-centered approach into the care they provided.

Implications and Recommendations

These research findings bring to light implications for nursing education, practice, policy and research, as well as for doula training and practice. As these implications and recommendations are described in the following sections, it is helpful to refer to the summary of findings in Figure 1 (illustrated on page 73). This will assist the reader in viewing how recommendations targeting the *influences on nurses' readiness to collaborate with doulas* are

important to consider both before and in tandem with those recommendations more specific to how nurses can improve collaboration with doulas in the intrapartum hospital setting in the *continuum of nurse-doula collaboration*. In this way, one can see how certain recommendations may be more relevant for intrapartum settings where more work is needed to first build a favourable environment for collaboration by targeting the influences before attempting to improve the individual interactions between nurses and doulas and the "how" of collaboration.

Previous recommendations to improve collaboration with doulas have mainly centered on improving interactions with doulas and increasing knowledge of their role (Ahlemeyer & Mahon, 2015; Amram et al., 2014; Ballen & Fulcher, 2006; Eftekhary et al., 2010; Klein et al., 2009; Neel et al., 2019; Roth et al., 2016; Waller-Wise, 2018). The findings from this study highlight the need to look further upstream and outward from the interaction itself to the influences within the practice context, targeting the outer layers of influence. These broad influences facilitate a more favourable environment for collaboration with doulas as well as a more favourable context in which to implement more specific recommendations to improve collaboration in practice at the individual nurse-doula level.

Nursing Education

The need for improved education for nurses and other HCPs regarding the role of doulas, their training, scope of practice and how to effectively work together when caring for a labouring patient in the hospital setting have been previously recommended by several authors (Ahlemeyer & Mahon, 2015; Amram et al., 2014; Ballen & Fulcher, 2006; Eftekhary et al., 2010; Klein et al., 2009; Neel et al., 2019; Roth et al., 2016; Waller-Wise, 2018). Nurse participants in this study reported receiving no formal training on the role of doulas and how to work with them. They described learning on the job and expressed that prior training about the doula role and what

doulas can and cannot do would make it easier to work with them. Ballen and Fulcher (2006) noted the need to dispel misconceptions about doulas and clarify the unique and shared roles of nurses and doulas. As noted by one participant, education is the foundation of any intervention to improve nurse-doula collaboration. Education has the potential to clarify roles, establish common nomenclature and quality standards, and contribute to greater understanding and respect for the unique contributions of doulas and nurses (Lucas & Wright, 2019).

Efforts also need to be made to increase appreciation for the evidence-based benefits of doula support and how the CLS provided by doulas is different from the labour support provided by nurses, as well as explain the mechanisms hypothesized for the improved maternal and neonatal outcomes associated with doula support. This explanation also needs to reinforce that doulas are not a replacement for high quality nursing care. Doula support is a complement to the labour support already provided by nurses. Nurses who feel threatened by the presence of doulas or who are territorial over their patients may feel differently once the doula role is better understood (Papagni & Buckner, 2006). In their practice recommendation for their study on nurses' intentions to provide continuous labour support (CLS), Payant et al. (2008) proposed that presenting the evidence to support the practice could influence nurses' attitudes, thereby moving nurses to change their behaviours related to CLS. This empirical-rational strategy for change rests on the assumption that providing information is a powerful motivator for change and nurses are more likely to adopt the change if they understand that it will benefit them and their patients (Sullivan, 2013; Udod & Wagner, 2018).

However, presenting the evidence may not be enough to influence nurses' practice. Klein et al. (2011) posited that "attitudes drive practice and often take precedence over evidence" (p.130). Graham et al. (2004) suggested there is a link between nurses' attitudes and behaviour

change. Klein et al. (2009) explained that differing attitudes are a result of diverse practice realities. Awareness of these different realities is integral to facilitating collaboration, encouraging team building and avoiding conflict (Klein et al., 2009). Therefore, as the findings from the present study suggest, it is imperative to look at the influences on nurses' attitudes towards doulas present in each practice context to plan interventions which focus on these influences. This is consistent with normative-reeducative change strategies that consider individuals' acceptance of change relies on the influence of social norms and values (Sullivan, 2013; Udod & Wagner, 2018); therefore, the focus is on integrating the identified positive *influences of nurses' readiness to collaborate with doulas* into education strategies.

In view of the *culture clash* between medicalized birth and natural birth, evidence-based physiologic birth practices need to be emphasized in nursing education. Birkhead et al. (2012) suggested that as a result of exposure to medicalized births in their clinical practicum, nursing students may begin to see highly medicalized care as the normal standard and integrate this into their view of childbirth and, in this way, women's preferences, right to informed choice and best practice evidence learned in lectures regarding physiologic birth fall to the background. Therefore, nursing students need structured opportunities to critically reflect on the highly medicalized births they have observed in the hospital setting and compare these with the evidence-based practices and patient-centered care approach learned in class (Birkhead et al., 2012; Canadian Association of Schools of Nursing, 2017). As in this study's findings, several authors have noted the influence of learning and practice environments on healthcare providers' attitudes towards birth and associated practices, such as doulas (Aschenbrenner et al., 2016; Klein et al., 2009; Lucas & Wright, 2019; Payant et al., 2008; Roth et al., 2016). Therefore, patient-centered care in the context of obstetrical care and patients' rights in birth also need to be

highlighted in entry level nursing education to build the foundation for these nurses' later practice and their professional attitudes towards birth. This will ultimately enable nurses and doulas to have a shared vision of birth and what constitutes "best care" (Eftekhary et al., 2010).

In these study findings and the published literature, the informational support and advocacy role of doulas have been highlighted as possible points of conflict due to lack of understanding of this doula role (Amram et al., 2014). Amram et al. (2014) explained that because "information giving and advocacy are areas where values and professional roles collide, they invite potential breakdown of communication in the labour room" (p.102). Further elucidation of these areas is needed for nurses to understand doulas' intentions and to avoid misunderstanding. This way, nurses can recognize that doulas are not trying to be difficult or challenging the nurses' authority or fostering mistrust, and thereby prevent the false allocation of blame to the doula when a patient chooses to refuse a particular suggested intervention (Amram et al., 2014). Doulas are simply facilitating patients' informed decision-making process. For example, doulas ask guiding questions, such as, "Would you like to know more about why this intervention is needed right now? Would you like to know more about the possible risks and benefits?" Education for nurses should reinforce that doulas can be both advocates for their patients and allies of the healthcare team (Ballen & Fulcher, 2006).

Doulas also need to recognize the pressures and constraints placed on nurses in the hospital settings through institutional policies, unit protocols and their medicolegal responsibilities in the care of their patients (Neel et al., 2019). Furthermore, doulas also need to know how to effectively communicate with nurses and other members of the maternity care team in the medical setting (Gilliland, 2002), as well as how to enter into a collaborative relationship with healthcare providers even in a less supportive setting (Amram et al., 2014).

Klein et al. (2011) explained that more exposure to each other during their education may help in creating improved positive interprofessional attitudes among members of the maternity team and more positive attitudes toward physiologic birth. More exposure would offer more opportunities to become familiar with each other, begin the process of building trust, and foster positive attitudes towards each other. Papagni & Buckner (2006) suggested that doulas should be invited to speak to nursing students during their initial training in maternal-child health to explain their role and how they can best work together to care for labouring patients in the hospital setting. Doulas could also be invited to speak with intrapartum nursing teams for an in-service or continuing education workshop (Waller-Wise, 2018). This would be an opportunity to become more familiar with local doulas, as well as discuss how nurses and doulas can collaborate in a variety of situations, such as considerations for high-risk patients who require additional interventions, mothers labouring with epidurals, planned c-sections, as well as running through mock emergency situations (Neel et al., 2019). This type of workshop could also be an opportunity for nurses and doulas to share some of their labour support techniques, so they can appreciate what each have to offer and foster mutual respect (Peterson et al. 2007). Shared opportunities for learning could also include a labour support training for both nurses and doulas to learn side by side and creates an environment for interprofessional collaboration (Steel et al., 2015). Doulas could also present at grand rounds (Neel et al., 2019).

Participants suggested that training on the doula role and how to work with doulas should be included in the initial orientation training to the intrapartum unit in addition to labour support training. This should also include the expectation of the nurse continuing to be present in the room and being available for labour support, as well as how to provide labour support when a doula is present. Furthermore, considering the influence of previous professional experiences and

training, students and newly hired or novice intrapartum nurses may be paired with preceptors who can be role models for providing patient-centered care and labour support, as well as promoting physiologic birth and demonstrating collaboration with doulas (Bott et al., 2011; Moore & Cagle, 2012; Powers et al., 2019; Ryan et al., 2010; Simmonds et al., 2013). As new trainees to the birthing unit may not see a birth with a doula during their orientation, preceptors can provide guidance by sharing their experiences in the form of stories about their previous experiences collaborating with doulas (Diekelmann & Diekelmann, 2009; Moore & Cagle, 2012). By using stories as a teaching medium, narrative pedagogy, nurses engage in a "process of sharing and collective interpretation, [where] preceptors and nurses co-create and transform knowledge to respond to previously held assumptions and ways of being" (Moore & Cagle, 2012, p.561). Nurse trainees can later mirror these collaborative behaviours in their future interactions with doulas.

Kardon-Edgren (2001) and Adams and Bianchi (2008) proposed that nurses working in intrapartum be required to complete a certification in labour support, just as they are required to be certified in electronic fetal monitoring, lending greater credibility and importance to this nursing responsibility. For example, the Champlain Maternal Newborn Regional Program (2021) offers a labour support workshop for intrapartum nurses in their region. It may not be feasible to train entire teams of nurses at once. A starting point for change may be to educate key people identified within a team in order to start a ripple of change before planning any training or in-service workshop for the team (Zwelling et al., 2006; Udod & Wagner, 2018). Adams and Bianchi (2008) proposed implementing a *Labour Support Day* once a month when a nurse with expertise in labour support is not assigned any patients and moves between labour rooms to

accompany less experienced nurses to guide and support them in providing hands-on labour support.

Nursing Policy

Policy recommendations need to be considered as they relate to the levels of influence described by the nurses. Participants' responses revealed that policies facilitated collaboration with doulas then they enabled nurses to provide labour support and encouraged them to see doulas as part of the interprofessional team. Therefore, policies which promote patient-centered care and support physiologic birth as institutional priorities could positively influence nurses' readiness to collaborate with doulas (Association of Women's Health, Obstetric and Neonatal Nurses, 2011; Halpern, 2009; Public Health Agency of Canada, 2021; World Health Organization, 2018; Zielinski et al., 2016). Association of Women's Health, Obstetric and Neonatal Nurses' (AWHONN, 2018) position statement on CLS recommends policies include thorough and ongoing training in labour support techniques and tools, identification of patients eligible for intermittent auscultation, adequate staffing policies that promote one-to-one nursing as the norm so nurses can be present to provide in-person labour support, and implement a liberal visitor policy so birthing patients can have the support persons they chose to provide effective labour support while ensuring a safe physical environment. These recommendations are also consistent with the Public Health Agency of Canada (2021) national guidelines for maternal-newborn care in labour and birth and the World Health Organization's (2018) recommendations for *Intrapartum care for a positive childbirth experience*. These aim to guide institutions worldwide to integrate evidence-based care to minimize unnecessary interventions and stresses how a woman-centered approach can lead to better outcomes for mothers and infants through a holistic human rights-based approach that highlights women's ability to give birth and respects

the impact of the birth experience (World health Organization, 2018). In their position statement on CLS, AWHONN (2018) reinforced that "nurse leaders, including unit managers, nurse educators, and clinical nurse specialists, can be instrumental in advocating for staffing levels that ensure the provision of CLS based on national guidelines" (Association of Women's Health, Obstetric and Neonatal Nurses, 2018). Managers and other nursing leaders can foster a culture of care that prioritizes CLS and implement appropriate unit policies to promote nurses having the time and ability to provide labour support (Association of Women's Health, Obstetric and Neonatal Nurses, 2018), as well as make clear their expectations of nurses' roles and responsibilities when patients are accompanied by their doulas (Public Health Agency of Canada, 2021). Nursing leaders also need to provide training on shared decision making (Association of Women's Health, Obstetric and Neonatal Nurses, 2011) and clear guidance regarding nurses' informational support and advocacy role. Adams and Bianchi (2008) suggested managers review consent forms, waivers and documentation standards with nurses so they can make use of these if their patients' choices or requests fall outside the usual unit care practices. This would also provide clearer guidance to nurses regarding how they are expected to respond if faced with the moral dilemma of at once being responsible for advocating for the patients' wishes while also being charged with ensuring the patient's safety, if they interpret that the patient or her fetus's safety is at risk by refusing usual care.

Other policies can be implemented to promote viewing doulas as members of the maternity team (Public Health Agency of Canada, 2021). Doulas can be included in institutional policies to recognize them as a part of the labour support team (Lucas & Wright, 2019; Mottl-Santiago et al., 2008; Public Health Agency of Canada, 2021; Waller-Wise; 2018). The *Canadian hospitals maternity policies and practices survey* recorded that only 16% of Canadian

hospitals had a written policy regarding doulas for labour support (Hanvey et al., 2012). These policies could allow doulas certain privileges, such as being present as a second support person in the operating room during caesarean sections, after completing a structured orientation to the unit and verification of their training or certification (Ahlenmeyer & Mahon, 2015; Lanning et al., 2018; Lanning et al, 2019; Lucas & Wright, 2019 Waller-Wise, 2018). This orientation would also ensure that doulas are familiar with the unit, the usual practices and what is available, and offer an opportunity to increase familiarity and clarify expectations to build trust (Ahlenmeyer & Mahon, 2015; Ballen & Fulcher, 2006; Lucas &Wright, 2019; Roth et al., 2016; Waller-Wise, 2018). The implementation of hospital-based doula programs would also integrate several of the facilitating influences for nurse-doula collaboration, as nurses would have more exposure to doulas, more opportunities to work together and become familiar with each other (Ahlenmayer & Mahon, 2015; Ballen & Fulcher, 2006; Lanning et al., 2018; Lanning et al., 2019; Waller-Wise, 2018). In these programs, doulas are either hired directly by the hospital, such as *The Birth Sisters* program at Boston Medical Center (Mottl-Santiago et al., 2008) or a doula agency partners with the hospital, such as the *Birth Doula Program* (Birth Doula Program, 2021) providing services to families delivering at The Scarborough Network and Markham Stouffville Hospital near Toronto. Furthermore, as the nurses gain more experience working with the familiar program doulas, they would increase their skills and willingness to work with doulas overall (their *readiness to collaborate with doulas*), including those from outside the program (Ahlenmayer & Mahon, 2015; Ballen & Fulcher, 2006; Neel et al., 2019; Roth et al., 2016; Waller-Wise; 2018). Hospital-based doula programs need to be integrated with caution and great consciousness that the doulas within them are truly serving the needs and choices of their birthing clients and not serving as instruments to fulfil a peripheral institutional agenda.

Public policy changes also need to occur. In view of the evidence-based benefits of CLS provided by doulas and considering that doulas can help mitigate the risk of poorer birth outcomes for disadvantaged, marginalized and vulnerable populations, several authors have advocated for government reimbursement and insurance coverage of doula services (Association of Women's Health, Obstetric and Neonatal Nurses, 2018; Eftekhary et al., 2010; Kozhimannil et al., 2013; Lucas & Wright, 2019; Neel et al., 2019; Zielinski et al., 2016). This would make doula services more accessible, especially for the families who could most benefit from them (Kozhimannil et al., 2013; Lucas & Wright, 2019; Neel et al., 2019). As such, several authors have described access to doula as a health equity issue (Kozhimannil et al., 2013; Lucas & Wright, 2019; Neel et al., 2019). In addition, expanded access to doulas would have the potential of reducing unnecessary interventions (Bohren et al., 2017; Simkin, 2018), improving outcomes and could save millions of healthcare dollars (Association of Women's Health, Obstetric and Neonatal Nurses, 2018; Greiner et al., 2019; Hanley & Lee, 2017; Kozhimannil et al., 2016).

Nursing Practice

Findings from this study and others point to several recommendations for nursing practice. To begin, nurses need to provide care in such a way that acknowledges that birth is not just another day in a woman's life and recognize that their words and actions have great impact on how their birthing patients will move forward as parents and how they will look back on their birth experience (Ayers et al., 2016; Lunda et al., 2018; MacKinnon et al., 2005; Simkin, 1991; Simkin 1992, Simkin, 1996; Papagni & Buckner, 2006; Pratt et al., 2021). As described by the study participants, it is recommended for nurses to adopt a patient-centered approach (Association of Women's Health, Obstetric and Neonatal Nurses, 2011; Registered Nurses Association of Ontario, 2015) and move forward with the common goal of safe and satisfying

birth when entering into collaboration with doulas (Ballen & Fulcher; Lucas & Wright, 2019; Zielenski et al., 2016). Nurses and doulas need to see each other as members of the patient's support team rather than "nurses" and "doulas". They may have different roles and scopes of practice (Ballen & Fulcher, 2006); however, their roles do overlap and complement each other for providing labour support in the intrapartum setting and provides an opportunity for collaboration for improved birth outcomes.

Nurses can begin to work toward their common goal with doulas by establishing a therapeutic nurse-patient relationship centered on mutual respect, viewing each patient as a unique individual and implementing shared decision making (Adams & Bianchi, 2008; MacKinnon et al., 2005; Registered Nurses Association of Ontario, 2015; Pratt et al., 2021). The present study contributes a greater understanding of how nurses do this. It involves going into the interaction with an open mind and demonstrating a willingness to adapt care to the patient's particular wishes and preferences. Nurses can observe what is already happening in the room and show respect for the patient's choice to have a doula by introducing themselves to the support team already in the room and inquiring about the labouring patient's wishes and preferences for birth and any plans the patient and doula may have already discussed prenatally. Participants then described taking a moment to clarify roles with the doula and discuss how the nurse and doula can best work together, so the nurse can do the assessments and other care responsibilities the nurse needs to do while taking into account the patient's preferences. This open communication allows the nurse to be aware of the patient's wishes and can open the discussion of any elements of the birth plan that may deviate for the unit's routine practices. This way, they can negotiate a mutually agreeable plan of care and clarify expectations if the occasion arises that an intervention is recommended that deviates from the plan (Adams & Bianchi, 2008).

Nurses are encouraged to be present in the room as much as possible to provide physical presence, emotional and informational support (Adams & Bianchi, 2008; MacKinnon et al., 2005). This way the nurse can observe the safe progress of labour, provide praise and encouragement, as well as offer to step-in and provide hands-on physical support as needed, giving the partner or other support team member and doula a much-needed break during long labours. Nurses need to remember that there is much more to labour support than direct hands-on physical support and even when their patient has a doula, women still want to connect with their nurse and for the nurse to be present to provide all elements of labour support (Adams & Bianchi, 2008; Gilliland, 2011; MacKinnon et al., 2005).

Being open-minded and providing non-judgemental care requires nurses to be aware of their own beliefs, values and attitudes regarding birth. Reflection is an essential nursing skill recognized in the Canadian Nurses Association's (2017) Code of Ethics and the College of Nurses of Ontario's Quality Assurance Program (2021). Nurses are encouraged to reflect on their own beliefs, values, attitudes, assumptions and interpersonal interactions (Canadian Nurses Association, 2017). Nurses need to be aware that they have power to shape women's choices though the information given if incomplete or biased, as well as through their verbal and non-verbal communication which can reflect their attitudes and approval or disapproval of the patients' choices (Simmonds et al., 2013). They need to be prepared to advocate for their patients' choices even if they do not agree with them (Adams & Bianchi, 2008).

Adams and Bianchi (2008) detailed several characteristics of advocacy in labour support. This included conveying respect through "[providing] complete information, [providing] non-judgemental care, [protecting] patient rights, and [respecting] existing relationships" (Adams & Bianchi, 2008, p.112). Advocacy also involves supporting women to make informed choices by

explaining the risks and benefits, supporting their choices with both their words and actions, relaying the preferences and plan to other members of the healthcare team and negotiating of the patient's behalf, as well as regularly revaluating and adjusting the plan as needed with the patient (Adams & Bianchi, 2008). Nurses need to reinforce that patients have the right to informed choice and advocate for their patients by providing complete evidence-based information, and giving the patient time to consider options (when not an emergency) without being pressured (Adams & Bianchi, 2008; Simmonds et al., 2013; Villarmea & Kelly, 2020). If nurses were consistently trained and expected to enact advocacy in such a way in the intrapartum hospital context, would doulas' informational support and advocacy role still be a source of discord in the same way? Responses from participants in this study encourage us to consider that this would facilitate collaboration with doulas.

Beyond reflecting on their individual beliefs and attitudes, nurses may also reflect on what has influenced these, as well as think about dominant birth culture in their practice setting and how this is reflected in their approach to care. Considering the medicalized hospital birth context where women's experiences of nursing presence are inextricably linked to the institutional environment and unit practices, MacKinnon et al. (2005) posed the following questions for nurses: (a) Does the biomedical hegemony that focuses on a safe delivery and a healthy baby create women as objects of our caring?" (p.34); (b) "Are we complicit as nurses in creating invisible women, women who are not seen or heard within our health care institutions?" (p.34).

Nurses working in the prenatal setting are in a position to share information about the benefits of doula support, as well as council expectant families on how to find a trained doula. This is especially important to consider for families who are at greater risk of poor outcomes due

to socioeconomic factors. Nurse can become familiar with community organizations and local community doulas who offer free and low-cost doula services in order to provide affordable options for families who can most benefit from doula services (Kozhimannil et al., 2013; Kozhimannil & Hardeman, 2016; Lucas & Wright, 2019; Neel et al., 2019).

Nursing Research

Participants identified several influences on their readiness to work with doulas which could be further explored in future research. Institutional ethnography could be considered as a methodology to investigate the social norms and contextual factors that affect how intrapartum nurses provide labour support (MacKinnon et al., 2005; Payant et al., 2008), both with and without doulas present. In order to further facilitate collaboration, there is a need to explore and clarify how nurses and other HCPs in the intrapartum hospital setting understand and define patient-centered care and what constitutes best care in the intrapartum setting. What is safe and satisfying birth? A series of case studies of nurses and doulas working in collaborative practice may be useful to further explore how nurses and doulas interact and negotiate the overlap in their labour support role in the hospital setting. This study also lends support for further research to develop and assess the effectiveness of interventions to promote collaboration between nurses and doulas, including how negative attitudes towards doulas can be ameliorated to encourage nurses to be open to collaborating with doulas. The doula perspective on how they work in collaborative practice with nurses needs to be further explored to gain a better understanding of the other group in this collaboration equation. Additionally, the partner perspective of nurses and doulas working together and the consequences of their interactions and the support offered to the partner has not yet been explored. Furthermore, mixed-methods research investigating the implementation of hospital-based doula programs and how these affect birth outcomes as well

study the integration of doulas in the interprofessional team and collaboration with doulas from the perspective of HCPs, since this type of program incorporates many of the facilitating influences noted in the study findings, such as supportive hospital policies, familiarity, training and competence, role clarification, trust, work experiences and more exposure to each other.

Strengths and Limitations

Strengths

This study specifically focused on the interaction and collaboration between nurses and doulas in the intrapartum period from the perspective of nurses, as they spend the most time with women in labour and the doulas who accompany them. Nurses' insights were isolated and not grouped with those of other healthcare providers, as done in previous studies. These findings provide insights from nurses for nurses. This study focused on what nurses are already doing that helps them to collaborate with doulas and revealed how they navigate the overlap in their labour support roles.

I had the advantage of approaching this study with multiple perspectives on the issue as a registered nurse as well as a DONA International certified birth doula. I had a deep understanding of these roles, the professional scope of practice and associated responsibilities. This was helpful in writing the initial interview guide and in asking for clarification during the interviews as well as understanding the intrapartum hospital setting context within which the study was performed. My thesis committee members also added their multiple professional practice backgrounds and diverse experiences in perinatal nursing by viewing the data from multiple perspectives to enhance interpretive authority (Graneheim & Lundman, 2004; Polit & Beck, 2012).

The participants shared their experiences from working in multiple intrapartum hospital units of varying levels of care in five locations across Ontario, from large urban hospitals to smaller community hospital settings, contributing to the richness of the data despite the small sample size of six participants. These findings represent what the nurse participants reported was already working for them in collaborating with doulas and have the potential to be more widely used by nurses and applied in similar intrapartum hospital settings. This interpretive description of how nurses and doulas work in collaborative practice in the intrapartum hospital setting can be used as guidance to prioritize practical recommendations at multiple levels of influence to facilitate collaboration between nurses and doulas in the hospital setting. It is important to consider that one intervention may be more appropriate to initiate first on one unit compared to another depending on the unit's unique needs and characteristics. These include the prevailing birth culture represented on the unit via the policies and practices that are already in place, labour support training and expectations of the nurses to provide labour support.

Both in-person interviews and interviews via Zoom videoconferencing were integrated in the initial data collection plan for this study. Two participants from the initial study setting opted to complete their interviews via Zoom videoconference prior to the COVID-19 pandemic in January 2020. Since Zoom videoconferencing was already in use, it was seamless and consistent to continue using this medium once physical distancing measures were in place for the subsequent interviews in July and September 2020. The use of Zoom videoconference also facilitated speaking with nurses from locations across Ontario.

Limitations

There were additional nurses at the original study site who voiced that they had experience working with doulas; however, they expressed that they would prefer to answer

questions in written form and did not elect to participate in an individual interview. Furthermore, the second half of the recruitment and data collection occurred during the COVID-19 pandemic, between June and September 2020, when nurses were coping with additional stressors and may not have been as inclined to use their time off to participate in research. Furthermore, during this time, doulas were prevented from accompanying their clients in labour as a second support person, as hospitals in Ontario and across North America implemented a single support person policy in their birthing units. This policy may have encouraged the view that collaborating with doulas and research in this area was not a priority at the time. The nurses who ultimately participated in the study were thus likely highly motivated due to holding more positive attitudes towards physiologic birth practices and doulas or having had more previous positive experiences working with doulas. Therefore, this group of participants may not necessarily represent the blend of intrapartum nursing attitudes towards birth. Nevertheless, these nurses provided valuable insights about what facilitated their nursing approach, what they thought influenced their attitudes, what was already working for them in their practice regarding working collaboratively with doulas, as well as how they learned to work with doulas. The participants also shared their perspective on how they think they are different from their nursing colleagues who have more difficulty collaborating with doulas, thereby affording some insight into what makes collaboration more difficult for some nurses and inversely what characteristics and practices facilitate collaboration. It would have been informative to speak with nurses who have more difficulty working with doulas in order to explore these alternative perspectives and experiences to further enrich the data.

Conclusion

The findings from this study highlighted four layers of influence on how nurses progress through a continuum of nurse-doula collaboration: societal birth cultures, hospital policies and support from managers, previous professional experiences, and having the approach to care that *"it's about the patient"*. Nurse participants illustrated how doulas can be helpful resource to learn about their patients' preferences for birth and how this facilitates establishing therapeutic relationships with their patients in labour. These findings offer greater insight into how intrapartum nurses build on the existing trusting relationship between the birthing person and her doula in order to begin establishing their therapeutic relationship with their labouring patients and provide safe individualized care, respecting their patient's choices and also fulfilling their nursing responsibilities set out by their unit. Furthermore, although the influences identified here are primarily described in layers, they are also interactive and reinforcing. Each of them present opportunities to facilitate collaborative practice between nurses and doulas.

Women and birthing families will continue to come into the hospital setting to give birth accompanied by their doulas, so nurses and other HCPs need to ensure that they and their practice settings are ready to welcome birthing families and their doulas. This way, parturient patients can enjoy the full benefits of the care provided by their nurses and their doulas both individually and collaboratively in the intrapartum hospital setting.

It is the professional responsibility of nurses to ensure that patients under their care receive the best care possible based on the best evidence available (Canadian Nurses Association, 2017; Canadian Association of Perinatal and Women's Health Nurses, 2018; Registered Nurses Association of Ontario, 2015). CLS provided by doulas is a well documented evidence-based practice for improving birth outcomes for mothers and their infants (Bohren et

al., 2017). This is especially significant for patients who are already at risk of adverse outcomes (Bohren et al., 2017; Kozhimannil et al., 2013; Neel et al., 2019). This study's findings are essentially about facilitating evidence-based patient-centred care. Intrapartum nurses, their fellow HCPs, and especially those in leadership are in a position to advocate for the implementation of this evidence-based practice and create birth environments that facilitate its integration and greater collaboration. Initiatives to increase access to doulas will ultimately increase nurses' exposure to doulas and provide more opportunities to become familiar with each other, their unique and shared roles, as well as build trust and facilitate future collaboration. Further collaboration requires engagement from both nurses and doulas. Doula organizations and individual doulas need to continue efforts to improve understanding of the doula role by the public and HCPs, as well as integrate practices and promote activities that facilitate collaboration with nurses and other HCPs, such as those proposed here. This way, doulas and nurses can move forward seeing each other as members of their patients' support team working together towards shared goals.

Doulas are not simply filling a gap in care. Greater collaboration presents an opportunity to enhance nurses' existing practice and to work together to meet the CLS needs of birthing women. Every effort should be made to ensure that nurses are well prepared to care for women who choose to be supported by their doulas in the intrapartum hospital setting. This way, nurses can fully utilize the help of doulas and birthing women can enjoy the full benefits of both nursing and doula support for optimal birth outcomes and positive birth experiences.

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Appendix A

Ethics Approvals from the Initial Study Hospital's Research Ethics Board and the University of Ottawa Office of Research Ethics and Integrity

Initial study hospital logo

Affilié à l'Université d'Ottawa | Affiliated with the University of Ottawa

Notice of Ethics Approval [redacted]

October 18, 2019

Principal Investigator:

Gabriela Morningstar Mizrahi
University of Ottawa
[redacted]

Responsible site Investigator and supervisor

Wendy Peterson
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Project title: « Facilitating Collaborative Practice Between Nurses and Doulas: Insights from Perinatal Nurses. »

File number: 19-20-09-023

Start date : October 18, 2019

End date : October 17, 2020

In accordance with the latest edition of Tri-Council Policy Statement - Ethical Conduct for Research Involving Humans Subjects (TCPS 2), I confirm that the [redacted] Research Ethics Board (REB) has evaluated and **approved the research project** and the following documents for the start and end dates mentioned above:

- Master thesis proposal submitted, dated August 22, 2019, submitted on September 4, 2019
- Thesis Proposal Approved on August 27, 2019, submitted on September 4, 2019
- Appendix A: DONA International Code of Ethics and Standards of Practice, revised on September 2016
- Appendix B: Respectful Maternity Care:Universal Rights of Childbearing Women(EN&FR),submitted on Sept. 4, 2019
- Appendix C: Recruitment email (EN & FR), version submitted on September 4, 2019
- Appendix D: Recruitment poster (EN & FR, version submitted on October 14, 2019
- Appendix E: Twelve Month Timeline, submitted on September 4, 2019
- Appendix F: Interview Questions and Probes (EN & FR), version submitted on October 14, 2019
- Appendix G : Individual Interview Consent Form (EN & FR), version 1 dated August 12, 2019
- General Consent Form, version 4 dated October 18, 2019 (EN & FR)
- Estimated study budget, submitted on September 4, 2019
- Zoom Videoconference instructions (EN & FR), version submitted on October 14, 2019

[redacted]

[redacted] REB is established and operates in compliance with the Clinical Practice Guidelines: Consolidated Guidelines of the International Council for the Harmonization of Technical Requirements for the Registration of Pharmaceuticals for Human Use (ICH-GCP E6), Part C, Title 5 of the Food and Drug Regulations, and The applicable regulations, Part 4 of the Natural Health Products Regulations; Part 3 of the Medical Devices Regulations, the "Code of Federal Regulations" of the United States, the Ontario Personal Health Information Protection Act, 2004, and the laws and regulations applicable in Ontario. [redacted] REB is registered with the U.S. Department of Health and Human Services (DHHS) and the Office for Human Research Protection (OHRP).

The protocol of the study cannot be amended without prior approval of the REB unless there is an immediate safety issue for the participants. You must notify the REB immediately of any changes, adverse event or new information that may increase the risk of the study, changing the course of the study or reach the safety of participants. The changes to the project and recruitment tools must be submitted to the REB. Please send us **four weeks before the due date of the notice of approval**, a final report to close the file or to request the renewal of the certificate of ethical approval for the study.

If you have any questions, please do not hesitate to contact the Research Ethics Office by phon[redacted] extension 2221 or e-mail [redacted]

[redacted]

Richard Carpentier, Ph. D.
Chair of the Research Ethics Board [redacted]

14/11/2019

Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

Lettre d'approbation administrative | Letter of administrative approval

Numéro de dossier / Ethics File Number	H-11-19-5208
Titre du projet / Project Title	Facilitating Collaborative Practice Between Nurses and Doulas: Insights from Perinatal Nurses
Type de projet / Project Type	Thèse de maîtrise / Master's thesis
CÉR primaire / Primary REB	[redacted]
Statut du projet / Project Status	Approuvé / Approved
Date d'approbation (jj/mm/aaaa) / Approval Date (dd/mm/yyyy)	14/11/2019
Date d'expiration (jj/mm/aaaa) / Expiry Date (dd/mm/yyyy)	17/10/2020

Équipe de recherche / Research Team

Chercheur / Researcher	Affiliation	Role
Gabriela Morningstar MIZRAHI	École des sciences infirmières / School of Nursing	Chercheur Principal / Principal Investigator
Wendy PETERSON	École des sciences infirmières / School of Nursing	Superviseur / Supervisor

Conditions spéciales ou commentaires / Special conditions or comments:

[redacted] REB File number: 19-20-09-023

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14/11/2019

Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

L'Université d'Ottawa a signé une Entente, conforme aux exigences de la plus récente version de l'EPTC et tout autre règlement ou législation applicable, permettant au CÉR ci-haut nommé d'être désigné comme CÉR primaire pour les projets de recherche où

1) les activités principales de recherche sont menées sous l'autorité ou sous les auspices de l'établissement lié au CÉR primaire et

2) Une partie du projet est également réalisé sous l'autorité ou sous les auspices de l'Université d'Ottawa.

Cette lettre confirme que l'Université d'Ottawa a autorisé que le CÉR primaire soit le CÉR officiel pour l'évaluation et la supervision de ce projet de recherche. Ceci n'est pas une approbation éthique.

Afin de nous aider à garder votre dossier à jour, veuillez soumettre une copie de toutes demandes de modification, renouvellement d'approbation éthique etc. soumis à et approuvé par le CÉR primaire dès qu'elles sont disponibles.

Cette approbation administrative est valide pour la durée indiquée ci-haut et est sujette aux conditions énumérées dans la section intitulée « Conditions spéciales ou commentaires ».

The University of Ottawa has signed an Agreement, compliant with current TCPS guidelines and any other applicable guidelines or legislation regarding multisite review, allowing the REB named above to serve as Board of Record (BoR) for research projects where

1) the main research activities are conducted within the auspices or jurisdiction of the BoR's institution and

2) parts of the project are also conducted under the jurisdiction or auspices of the University of Ottawa.

This letter confirms that the University of Ottawa has authorized the REB named above to serve as Board of Record for the review and oversight of this research project. This is not an REB approval.

In order to help us keep your file up to date, please submit a copy of all amendment requests, project renewals or any other changes submitted to and approved by the BoR, as they become available.

Administrative approval is valid for the period indicated above and is subject to the conditions listed in the section entitled «Special conditions or comments».

Catherine PAQUET
Directeur / Director
Pour/For **Daniel LAGAREC** Président(e) du/ Chair of the **Comité d'éthique de la recherche en sciences de la santé et sciences / Health Sciences and Sciences Research Ethics Board**

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Appendix B

Healthcare Professional Organization Published Support for Continuous Labour Support (CLS) Provided by Doulas

Organization name	Year	Publication title	Statement
American College of Obstetricians and Gynecologists (ACOG) & Society for Maternal-Fetal Medicine (SMFM)	2014 (reaffirmed in 2016)	*Obstetric Care Consensus: Safe prevention of the primary cesarean*	"Published data indicate that one of the most effective tools to improve labor and delivery outcomes is the continuous presence of support personnel, such as a doula. A Cochrane meta-analysis of 12 trials and more than 15,000 women demonstrated that the presence of continuous one-on-one support during labor and delivery was associated with improved patient satisfaction and a statistically significant reduction in the rate of cesarean delivery. Given that there are no associated measurable harms, this resource is probably underutilized." (ACOG & SMFM, 2014)
Society of Obstetricians and Gynecologists of Canada (SOGC)	2016	*SOGC Clinical Practice Guideline: Management of spontaneous labour at term in healthy women*	"CLS is defined as non-medical care provided during labour that includes continuous presence, emotional support, comfort measures, advocacy, information, and advice. CLS may be provided by a trained person such as a doula, nurse, or midwife or from a friend or family member of the woman's choice. A 2013 Cochrane review of over 15000 women in low and middle-resource settings showed that CLS increased the likelihood of vaginal delivery, lowered the risk of Caesarean delivery, reduced the use of epidural analgesia, and improved Apgar scores and maternal satisfaction. Subgroup

			analyses showed that CLS was most effective when the provider was not part of the hospital staff or from the women's social network."(Lee et al., 2016, p.850) Recommendation: "Continuous labour support is recommended for all women in active labour. Each labour unit should aim to provide the opportunity for each woman to receive continuous 1-to-1 labour support." (Lee et al., 2016, p.850)
Society of Obstetricians and Gynecologists of Canada	2007	*Fetal health surveillance: Antepartum and intrapartum consensus guideline*	"Despite the fact that many organizations have concluded that one-to-one nursing care and support in labour is a priority, the review by Hodnett et al. concluded that continuous nursing care in labour would not have the same beneficial effects. However, because it is known that the birth experience can have a lasting, even lifelong, effect on women's psychological well-being, every effort should be made to provide women in labour with continuous support." (Liston et al., 2007, p.S28) Recommendation: "Women in active labour should receive continuous close support from an appropriately trained person." (Liston et al., 2007, p.S28)
Association of Women's Health Obstetric and Neonatal Nurses (AWHONN)	2018	*Continuous Labour Support for Every Woman (AWHONN Position Statement)*	"The RN coordinates the woman's support team, which may include a partner, family, friends, and/or a doula, to assist the woman to achieve her childbirth goals. Care and support during labor are powerful nursing functions, and it is

	incumbent on health care facilities to provide a level of staffing that facilitates the unique patient–RN relationship during childbirth. AWHONN recognizes that childbirth education and doula services contribute to the woman's preparation for and support during childbirth and supports consideration of these services as a covered benefit in public and private health insurance plans" (AWHONN, 2018, p. 73). Recommendations: "Liberal visitor policies permitting a woman to have the support persons she desires to provide her effective support, in accordance with maintaining a safe physical environment" (AWHONN, 2018, p.74). "Providing coverage and reimbursement for childbirth education and doula services that improve birth outcomes and save health care dollars should be a priority. As covered benefits for all pregnant women, these services could enhance goals to reduce racial and ethnic disparities in birth outcomes" (AWHONN, 2018, p.74)

Appendix C

Search Strategy

A search of CINHAL, Scopus, and Medline databases was performed using the search terms presented in Table 2 below. “Attitude” was added as a search term as it was a relevant topic in articles about doulas and nurses. “Conflict” was added as this came up in the abstracts from the initial search. “Collaboration” was added to refine the search. “Canada” was included in order to capture articles which were relevant to the Canadian context. Truncation of search terms was used to capture articles which used variations of the search terms. No publication date restrictions were applied.

Inclusion criteria was the following:

- Must include doulas as part of the main focus of research.
- Must address work of doulas and healthcare providers or nurses working together.
- Must include nurses who work in the hospital intrapartum setting or doulas working in the intrapartum setting.
- Full text must be available either English or French.
- Must be peer-reviewed.

Exclusion criteria was the following:

- Doulas are not included in the topic of focus.
- All articles not relevant to the described search. For example, articles about death doulas.

There were several steps in selecting articles for inclusion in the literature review. Titles from the initial search results were reviewed for inclusion. Abstracts from the retained articles were then reviewed for the inclusion and exclusion criteria. One scoping review of doulas in

Canada initially met the inclusion criteria, but was later excluded since the authors did not strictly respect their exclusion criteria and most of the studies included did not have doulas in the topic of focus. Several database searches yielded the same articles. In addition, reference lists from relevant articles were individually hand searched for further pertinent articles.

Table 2

Summary of Database Search Terms

	Database	Search terms
1.	CINAHL	nurse* AND doula*
2.	CINAHL	nurse* AND doula* AND attitude*
3.	CINAHL	nurse* AND doula* AND conflict*
4.	CINAHL	nurse* AND doula* AND collaboration
5.	CINAHL	doula* AND Canada
6.	Medline	doula* AND nurse*
7.	Medline	doula* AND conflict
8.	Medline	nurse* AND doula* AND attitude*
9.	Medline	nurse* AND doula* AND collaboration
10.	Medline	doula* AND Canada
11.	Scopus	doula* AND nurse*
12.	Scopus	doula* AND nurse* AND birth
13.	Scopus	nurse* AND doula* AND attitude*
14.	Scopus	nurse* AND doula* AND collaboration
15.	Scopus	doula* AND Canada

Appendix D

Bilingual Initial Study Hospital Recruitment Email

Hello,

My name is Gabriela Mizrahi. I am writing to you today because I am looking for registered nurses from [redacted]Family Birthing Centre who are willing to participate in an interview for my thesis research project exploring collaboration between nurses and birth doulas in the hospital setting.

I am currently a student at the University of Ottawa pursuing my master's degree in nursing under the supervision of Dr. Wendy Peterson.

I am looking for nurses who have had at least one experience of working with a client who had a doula present during labour in the last 10 years.

The 1:1 interview can be done at your convenience, either in person or via Zoom videoconference, to accommodate your schedule.

Your participation is entirely voluntary. You can choose to end your participation at any time.

By participating in this research study, you will be assisting to further the understanding of collaboration between doulas and nurses in the intrapartum hospital setting from nurses' perspectives.

A $10 gift card to Tim Hortons will be offered as a token of appreciation for your participation.

If you are interested in participating or if you have any questions, please email me at the following address [redacted]

Thank you,

Gabriela Mizrahi, RN, BN, CD(DONA), MScN student

Bonjour,

Je m'appelle Gabriela Mizrahi. Je vous écris aujourd'hui parce que je suis à la recherche d'infirmières et infirmiers autorisés du Centre familiale de naissance d[redacted] qui souhaitent participer à une entrevue dans le cadre de mon projet de recherche de thèse sur la collaboration entre les infirmières et les doulas (accompagnantes à la naissance) en milieu hospitalier.

Je suis actuellement étudiante à la maîtrise en sciences infirmières à l'Université d'Ottawa sous la supervision de la Dre Wendy Peterson.

Je recherche des infirmières ayant au moins une expérience avec une cliente qui a eu une doula présente pendant le travail à l'hôpital au cours des 10 dernières années.

L'entrevue 1:1 peut être tenue à votre convenance, soit en personne, soit par vidéoconférence Zoom, selon votre horaire et votre préférence.

Votre participation est entièrement volontaire. Vous pouvez choisir de mettre fin à votre participation à tout moment.

En participant à cette étude de recherche, vous contribuerez à approfondir la compréhension de la collaboration entre les doulas et les infirmières en milieu hospitalier intrapartum du point de vue des infirmières.

Une carte-cadeau de 10$ à Tim Hortons sera offerte en guise de remerciement pour votre participation.

Si vous êtes intéressé à participer ou si vous avez des questions, s'il vous plaît envoyer un courriel à l'adresse suivante [redacted]

Merci,
Gabriela Mizrahi, RN, BN, CD(DONA), étudiante MScN

Appendix E

Bilingual Initial Study Hospital Recruitment Poster

Initial study hospital logo

LA RECHERCHE DE VOLONTAIRES

Infirmières!
Avez-vous déjà travaillé avec une doula (accompagnante à la naissance)?

Nous recherchons des infirmières qui souhaitent participer à une entrevue de 30 à 45 minutes, au sujet de leur expérience comme infirmières, travaillant avec les doulas à l'hôpital.

Une carte-cadeau électronique de $10 pour Tim Hortons vous sera remise par courriel, en guise de remerciement pour votre participation à l'entrevue.

Critères de sélection :

- Infirmière autorisée au Centre familiale de naissance
- Avoir travaillé au moins une fois avec une doula lors d'une naissance au cours des 10 dernières années (au CFN ou à un autre hôpital).
- Les participants peuvent avoir employé une doula pour leur propre accouchement.

Si vous êtes intéressé(e) ou si vous avez des questions, communiquez avec :

Gabriela Mizrahi, RN, BN, CD(DONA), MScN Student
[redacted]

Ce projet a été approuvé par le comité d'éthique de la recherche de [redacted]

LOOKING FOR VOLUNTEERS

Nurses!
Have you worked with a birth doula?

We are looking for nurses to participate in a 30-45 minute interview about their experience as intrapartum nurses working with doulas in the hospital.

Participants will receive a $10 electronic gift card for Tim Hortons via email, as a token of appreciation for taking the time to participate in the interview.

Selection criteria:

- Registered Nurse at the Family Birthing Centre
- Have had at least one experience working with a doula in the hospital in the last 10 years (at the FBC or at another hospital).
- Participants can have employed a doula for their own birth experience.

If you are interested or have questions, please contact:

Gabriela Mizrahi, RN, BN, CD(DONA), MScN Student
[redacted]

This project has been approved by the [redacted] Research Ethics Board.

[redacted]

Appendix F

Recruitment Message for Canadian Association of Perinatal and Women's Health Nurses

(CAPWHN) Online Forum

Hello,

My name is Gabriela Mizrahi. I am writing to you today because I am looking for registered nurses who work in labour and delivery in Ontario who are willing to participate in a 30-45 minute interview for my thesis research project exploring collaboration between nurses and birth doulas in the hospital setting.

I am currently a student at the University of Ottawa pursuing my master's degree in nursing under the supervision of Dr. Wendy Peterson.

I am looking for nurses in Ontario who have had at least one experience of working with a client who had a doula present during labour in the last 10 years.

The 1:1 interview will be done at your convenience via Zoom videoconference, to accommodate your schedule. The interview can be done in either English or French. The interview will be audiorecorded using an external digital recorder (not video-recorded).

Your participation is entirely voluntary. You can choose to end your participation at any time.

By participating in this research, you will be assisting to further the understanding of collaboration between doulas and nurses in the intrapartum hospital setting from nurses' perspectives.

An electronic $10 gift card to either Tim Hortons or Indigo/Chapters will be offered according to your preference as a token of appreciation for your participation.

If you are interested in participating or if you have any questions, please email me at the following address [redacted]

Thank you,

Gabriela Mizrahi, RN, BN, CD(DONA), MScN student

Appendix G

Demographic Questions and Interview Guide

Demographic Interview Questions

1. What is your mother tongue? What language do you feel most comfortable using?
    a. English
    b. French
    c. Other: _____
2. Were you born in Canada?
    a. Yes
    b. No If no, what year did you arrive in Canada? _____
    c. Prefer not to answer
3. How many years have you worked as a registered nurse?
4. Where do you currently work? (What hospital birthing centre/labour and delivery unit?)
5. How many years have you worked at this birthing center/labour and delivery unit?
6. Did you work at another birthing centre before being employed at your current institution?
7. What is your highest level of education?
    a. College or CEGEP
    b. Undergraduate university degree
    c. Graduate university degree
8. Do you have any additional training/certifications relevant to your practice in perinatal nursing? i.e. CNA certification, doula training, midwife in another country, or IBCLC.

9. How many times have you worked with a patient in labour who was accompanied by a doula?
10. Were you ever accompanied by a doula for the birth(s) or your own child(ren)?
11. How well do you know the role of doulas during labour and birth?
    a. I do not know about the role at all
    b. I know about their role a bit
    c. I know about their role well
    d. I know about their role very well

Questions démographiques

1. Quelle est votre langue maternelle? Dans quelle langue vous sentez-vous le plus à l'aise?
    a. Anglais
    b. Français
    c. Autre : _____
2. Êtes-vous né au Canada?
    a. Oui
    b. Non Si non, en quelle année êtes-vous arrivé au Canada?
    c. Préfère ne pas répondre
3. Depuis combien d'années travaillez-vous comme infirmière autorisée?
4. Où travaillez-vous actuellement? (Quel centre de naissance / unité d'accouchement hospitalier?)
5. Depuis combien d'années travaillez-vous dans ce centre de naissance / unité d'accouchement?

6. Avez-vous travaillé dans une autre unité de naissance avant d'être employé(e) dans votre établissement actuel ? 7. Quel est votre niveau d'éducation le plus haut?

a. Collège ou CÉGEP
b. Diplôme universitaire de premier cycle
c. Diplôme universitaire supérieur

8. Avez-vous une formation supplémentaire/des certifications pertinentes pour votre pratique en soins infirmiers périnatals? Par example, certification AIIC, formation d'accompagnante à la naissance, sage-femme dans un autre pays ou IBCLC.

9. Combien de fois avez-vous travaillé avec une patiente en travail accompagnée d'une doula?

10. Avez-vous déjà été accompagné d'une doula pour la naissance ou vos propres enfants?

11. Connaissez-vous bien le rôle des doulas pendant le travail et la naissance?

a. Je ne connais pas du tout le rôle
b. Je connais un peu leur rôle
c. Je connais bien leur rôle
d. Je connais très bien leur rôle

Interview Questions and Probes

Thank you for agreeing to participate in this interview. As you know, we are interested in speaking with you about working with doulas when caring for women in labour in the intrapartum hospital unit. We would like to know about how you work with doulas, about the skills and approaches that you use, and about the characteristics of your unit, the people with whom you work and characteristics and approaches of doulas that facilitate or impede your collaboration with doulas.

We want to know what you and other nurses actually do, not what they are supposed to do. You may not know all the answers for all of the questions. You may also choose to skip a question if you are uncomfortable answering. We are not evaluating or judging your answers. There are no right or wrong answers. We really need you to be honest. While the study team will take precautions to protect your confidentiality, we encourage you to refrain from using names. If names or other identifying information is shared during the discussion, it will not be included in the written records. Do you feel comfortable and in a location that ensures your privacy adequately?

Do you have any questions about your participation in this interview at this point?

Please feel free to ask questions or stop at any time during the interview.

Now, I will turn on the tape recorder and begin the interview questions.

Open-ended Interview Questions

1. What is your current position and role?
2. Tell me about your unit.
    a. Who are the other professionals you work with?
    b. How would you describe the birth culture of your unit?

3. Tell me about a time when you worked with a client in labour who had a doula.
    a) Probe: What do you think made it go well when it did?
    b) Probe: What do you think led to that not going well when it didn't?
4. How does your care of a client accompanied by a doula differ from your care for a client without a doula?
    a. Probe: Tell me about why it is necessary to adapt your care when a doula is present.
5. What do you think contributes to your positive experiences when it comes to working with doulas in the hospital?
    a. Probe: Tell me about the skills/qualities that are essential for collaborating with doulas.
    b. Probe: How do you think this might be different from your colleagues?
6. What helps you work collaboratively with a doula?
    a. Probe: What are the characteristics/policies of your unit/hospital that help you work collaboratively with doulas?
7. What makes it more difficult to work with a doula?
8. How did you learn to work with doulas?
9. How has your approach changed over time?
    a. What do you think motivated this change?
10. Tell me why some nurses have more difficulty working with doulas.
11. What do you think has influenced your practice with doulas?
    a. Probe: What context has most influenced this?
12. How would you describe the role of a doula?

13. How would you describe the role of an intrapartum nurse?

Probes:

- Tell me more about that.
- Can you tell me more about that?
- Could you give me an example?
- What do you think makes that stand out in your memory?
- What was significant about that interaction?
- What might make you respond differently?
- How do you do that?

Are there any other comments you would like to make that might help us understand the determinants that influence collaborative practice between nurses and doulas in the intrapartum hospital setting?

Questions d’entrevue

Merci d'avoir accepté de participer à cette interview. Comme vous le savez, nous souhaitons discuter avec vous de la collaboration avec les doulas lorsque vous travaillez avec les femmes en travail au Centre familial de naissance. Nous aimerions savoir comment vous travaillez avec les doulas, les compétences et les approches que vous utilisez, les caractéristiques de votre unité, les personnes avec lesquelles vous travaillez et les caractéristiques et approches des doulas qui facilitent ou gênent votre collaboration avec les doulas.

Nous voulons savoir ce que vous et les autres infirmiers et infirmières faites réellement, non pas ce que vous êtes censés faire. C’est possible que vous ne connaissiez pas les réponses à toutes les questions. Vous pouvez également choisir de ne pas répondre à une ou plusieurs des questions si vous ne souhaitez pas y répondre. Nous n'évaluons ni jugeons vos réponses. Il n'y a pas de bonnes ou de mauvaises réponses. Nous avons vraiment besoin que vous soyez honnête. Bien que l'équipe de l’étude prenne des précautions pour protéger votre confidentialité, nous vous encourageons à ne pas utiliser de noms. Si des noms ou autres informations d'identification sont partagés au cours de la discussion, ils ne seront pas inclus dans les transcriptions de l’entrevue.

- Vous sentez-vous à l'aise et dans un endroit garantissant la protection de votre vie privée de manière adéquate?
- Avez-vous des questions sur votre participation à cette entrevue à ce stade?
- S’il-vous-plait, n'hésitez pas à poser des questions ou à arrêter à tout moment au cours de l’entrevue.
- Je vais maintenant allumer le magnétophone et commencer les questions de l'entrevue.

Questions ouvertes d'entrevue

1. Quel est votre rôle actuel?
2. Parlez-moi de votre unité.
    a. Avec quels autres professionnels travaillez-vous?
    b. Comment décririez-vous la culture/les pratiques de votre unité pour l'accouchement?
3. Parlez-moi d'une occasion où vous avez travaillé avec une cliente en travail qui avait une doula.
    a. Suivi : Selon vous, qu'est-ce qui a fait que ça se passe bien?
    b. Suivi : Selon vous, qu'est-ce qui a fait que ça se passe mal?
4. En quoi le traitement de votre cliente accompagnée d'une doula diffère-t-il de celui d'une cliente sans doula?
    a. Suivi : Pourquoi est-il nécessaire d'adapter vos soins en présence d'une doula?
5. Selon vous, qu'est-ce qui contribue à votre expérience positive à travailler avec les doulas à l'hôpital?
    a. Suivi : Parlez-moi des compétences/qualités essentielles pour collaborer avec les doulas.
    b. Suivi : Comment pensez-vous que cela pourrait être différent de vos collègues?
6. Qu'est-ce qui vous aide à travailler en collaboration avec une doula?
    a. Suivi : Quelles sont les caractéristiques/politiques de votre unité / hôpital qui vous aident à collaborer avec les doulas?
7. Qu'est-ce qui rend plus difficile la collaboration avec une doula?
8. Comment avez-vous appris à travailler avec les doulas?

9. Comment votre approche a-t-elle changé au fil du temps?
    a. Suivi : Selon vous, qu'est-ce qui a motivé ce changement?
10. Dites-moi pourquoi certaines infirmières ont plus de difficultés à travailler avec des doulas.
11. Selon vous, qu'est-ce qui a influencé votre approche avec les doulas?
    a. Suivi : Quel contexte a le plus influencé cela?
12. Comment décririez-vous le rôle d'une doula?
13. Comment décririez-vous le rôle de l'infirmière qui offert des soins intrapartum ?

Exemples de questions de suivi :

- Dites-moi en plus à ce sujet.
- Pouvez-vous m'en dire plus à ce sujet?
- Pouvez-vous me donner un exemple?
- Selon vous, qu'est-ce qui fait que cela se démarque dans votre mémoire?
- Qu'est-ce qui était significatif dans cette interaction?
- Qu'est-ce qui pourrait vous faire réagir différemment?
- Comment faites-vous cela?

Avez-vous d'autres commentaires qui pourraient nous aider à comprendre les facteurs qui influencent la collaboration entre les infirmières et les doulas durant la période intrapartum?

Appendix H

English and French Versions of the General Consent Form

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General Consent Form

GENERAL INFORMATION
Project Name: Collaborative Practice Between Doulas and Nurses: Insights from Perinatal Nurses

Principal Researcher's Name:
Gabriela M. Mizrahi, RN, BN, CD(DONA),
University of Ottawa, Master of Science in Nursing (thesis) student
Email [redacted]

Thesis Supervisor:
Wendy E. Peterson, RN, PhD
Associate Professor, School of Nursing, Faculty of Health Sciences, University of Ottawa
Email: wendy.peterson@uottawa.ca
Phone: 613-562-5800 ext. 8207

Names of Thesis Committee Members:
Josephine B. Etowa, PhD
Full professor, University of Ottawa, Faculty of Health Sciences, School of Nursing

France Morin, MScN
Clinical Manager, Family Birthing Centre, Hôpital Montfort

Conflicts of Interest: The researchers have no apparent or potential conflicts of interest to disclose.

2. INTRODUCTION
Before agreeing to participate in this research project, please take the time to read and carefully consider the following information. This document explains the purpose of the research project, its procedures, benefits, risks and drawbacks. Please ask the person who gave you this document any questions you consider relevant.

3. INVITATION TO PARTICIPATE
I am being asked to participate in the above-named research project conducted by Gabriela M. Mizrahi of the University of Ottawa, Faculty of Health Sciences, School of Nursing, under the supervision of Dr. Wendy E. Peterson of the School of Nursing, Faculty of Health Sciences, University of Ottawa.

I am free to participate in this optional study or not. My decision to participate or withdraw from the study will not affect my employment, nor the quality of service provided to me now or in the future in any way.

4. PURPOSE
The purpose of the study is to explore collaborative practice between intrapartum nurses and birth doulas in the hospital setting from the perspective of nurses and identify the determinants of collaborative practice which can inform nursing best practices when working with a patient who is accompanied by a doula.

5. INCLUSION/EXCLUSION CRITERIA
Inclusion criteria: Registered nurses in a hospital birthing centre (labour and delivery unit) in Ontario and who have worked at least once with a doula during a birth in the last 20 years. Nurses who employed a doula for their own birth experience are eligible to participate.

Exclusion criteria: Registered practical nurses, nurses who have never worked with a doula, and nurses currently being oriented to intrapartum are not eligible to participate. Nurses working outside of Ontario are not eligible to participate.

6. PARTICIPATION
My participation will essentially consist of partaking in a 30 to 45 minute individual interview, during which I will be asked about my experience and insights regarding collaboration with doulas in the hospital setting. The interview will be

audiorecorded with a digital recorder and transcribed verbatim following the interview. The interview will be scheduled for a date and time that is convenient for me between October 2019 and September 2020. The interview will be conducted via Zoom videoconference. Interviews conducted via Zoom videoconference will only be audiorecorded with the same external digital recorder as the in person interviews.

7. BENEFITS

My participation in this research will allow the researchers to explore and further understand collaborative practice between nurses and doulas in the intrapartum hospital setting from the perspective of nurses. The findings from this study will provide valuable insights from the individuals involved and allow for discovery of themes and determinants that influence collaborative practice that can then be used to inform interventions to promote greater collaborative practice between nurses and doulas and take a step towards ensuring that nurses are better prepared to work with doulas, and parturient women with doulas can enjoy the full evidence-based benefits of this support and the support of intrapartum nurses.

8. RISKS

During the interview, I may intentionally or unintentionally:

- mention individual's names

I understand that any names and identifiable information that I mention will be omitted from the written record. I have the researcher's assurance that any information I share with her will be kept strictly confidential except when required by law.

9. DATA CONSERVATION

The data gathered, interview digital recordings and transcriptions, will be kept in a secure manner. The interview audiorecordings will be kept after they have been transcribed, as they will be used during the data analysis of the study in tandem with the interview transcriptions. They will be saved on the main researcher's password protected laptop and the supervisor's computer at the UOttawa School of Nursing until the data analysis is completed, Printed transcripts will not have any identifying information contained within them. All other physical documents will be kept in the thesis supervisor's locked office (UOttawa RGN room 1118). Copies of all materials will be kept for 7 years. The Zoom videoconferencing internal recording system will not be used to record the interview. An external digital recorder will be used to audiorecord the interviews conducted via Zoom conference. In order to participate in a Zoom conference interview on the computer, I will need to follow the unique web link sent to me by email by the principal researcher or follow the instructions for alternate methods to join the online interview sent to me by email by the principal researcher. I may use only my first name or a pseudonym when entering the Zoom meeting, as per the instructions sent to me by email by the principal researcher.

10. CONFIDENTIALITY AND ANONYMITY

I have the researcher's assurance that any information I share with her will be kept strictly confidential except when required by law. I expect that the content will be used only for qualitative data analysis and with respect for confidentiality. My personal story will not be shared with my immediate supervisor or employer. Confidentiality is guaranteed as follows. Transcribed audio-recordings will be de-identified by a professional transcriptionist. Digital files of the recordings and transcriptions will be labeled with the date and time of the interview and a numerical code. A master list matching the participants' names and the numerical codes will be kept as an electronic file in folder separate from the study data on the researcher's laptop and the supervisor's computer at the School of Nursing. Only the main researcher and supervisor will have access to the master list. Only the principal researcher, thesis supervisor and thesis committee member, Dr. Josephine B. Etowa, will have access to the de-identified demographic data and interview transcriptions. Thesis committee member, France Morin, will participate in data analysis discussions, but will not have access to the transcriptions or any identifying information. The professional transcriptionist has signed a confidentiality form prior to beginning transcription. However, I have been given assurances that no record identifying me, by name or initials, for example, will be permitted to leave the researcher's office.

11. VOLUNTARY PARTICIPATION

My participation in the study is voluntary. I am free to withdraw at any time or to refuse to answer certain questions without exposing myself to any negative consequences. To withdraw from the study, I must contact the principal

researcher or her supervisor at the email listed above to inform the study team of my decision to withdraw. If I decide to withdraw from the study, at my request, the data gathered up to that time, including audiorecordings and subsequent transcriptions, will be destroyed. The audio-recordings and digital files will be deleted and physical copies of transcriptions will be shredded.

I will be informed at the appropriate time if any new information arises that might affect my interest in continuing to participate in the study.

12. REIMBURSEMENT/COMPENSATION

I will receive a $10 electronic gift card for Tim Hortons or Indigo/Chapters (according to my preference) via email, as a token of appreciation for taking the time to participate in the interview.

13. NOTIFICATION OF RESULTS

I can request to be emailed a copy of Gabriela M. Mizrahi's the final thesis which will include the results of this study. The results of this study may also be published in professional journal(s) and conference(s).

14. CONSENT

Acceptance: I,_____, agree to participate in this research project conducted by Gabriela M. Mizrahi under the supervision of Dr. Wendy E. Peterson. For any further information concerning this study, please contact the researcher or the researcher's supervisor.

For information concerning ethical aspects of this research, I may contact the [redacted] Research Ethics Board, [redacted] Road, suite 102 Ottawa, Ontario by telephone at [redacted] extension 2221, or by email at [redacted]

There are two copies of the consent form, one of which I may keep.

Participant's Signature: Date:

Researcher's Signature: Date:

If a participant is unable to read the consent form (blind, etc.) or unfit to provide consent (child, cognitive impairments, etc.), space must be added for the signature of a witness or authorized third party. N.B. Do not include this section if it does not apply to your project. If necessary, refer to TCPS 2 for more details: Chapter 3, *The Consent Process* (p. 29-48).

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Formulaire de consentement général

1. RENSEIGNEMENTS GÉNÉRAUX

Titre du projet : Collaboration entre les doulas et les infirmiers et infirmières: Perspectives des infirmières périnatales

Nom du chercheur principal :
Gabriela M. Mizrahi, RN, BN, CD(DONA),
Université d'Ottawa, Étudiante de Maîtrise en sciences infirmières (thèse) Courriel [redacted]

Superviseure de thèse:
Wendy E. Peterson, PhD
Professeure agrégée, Université d'Ottawa, Faculté des sciences de la santé, École des sciences infirmières
Courriel: wendy.peterson@uottawa.ca
Téléphone: 613-562-5800 ext. 8207

Membres du comité de thèse:
Josephine B. Etowa, PhD
Professeure titulaire, Université d'Ottawa, Faculté des sciences de la santé, École des sciences infirmières

France Morin, MScN
Gestionnaire clinique, Centre familial de naissance, Hôpital Montfort

Conflits d'intérêts : Les chercheurs n'ont aucun conflit d'intérêt apparent ou potentiel à divulguer.

2. INTRODUCTION

Avant d'accepter de participer à ce projet de recherche, veuillez prendre le temps de lire et de comprendre les renseignements qui suivent. Ce document vous explique le but de ce projet de recherche, ses procédures, avantages, risques et inconvénients. Nous vous invitons à poser toutes les questions que vous jugerez utiles à la personne qui vous présente ce document.

3. INVITATION À PARTICIPER

Je suis invité (e) à participer à la recherche nommée ci-dessus qui est menée par Gabriela M. Mizrahi de l'Université d'Ottawa, Faculté des sciences de la santé, École des sciences infirmières, sous la supervision de Dr. Wendy E. Peterson de l'École des sciences infirmières de la Faculté des sciences de la santé, Université d'Ottawa.

Je suis libre de participer ou non à cette étude. Ma décision de participer ou de me retirer de l'étude n'affectera en rien mon emploi, ni la qualité des services qui me sont offerts actuellement ou me seront offerts à l'avenir.

4. BUT DE L'ÉTUDE

Le but de l'étude est d'explorer la collaboration entre les infirmières qui offrent des soins intrapartums et les doulas en milieu hospitalier du point de vue des infirmières et d'identifier les déterminants du travail collaboratif qui pourraient informer les meilleures pratiques pour les infirmières lorsqu'elles travaillent avec une patiente accompagnée d'une doula.

5. CRITÈRES D'INCLUSION ET D'EXCLUSION

Critères d'inclusion: Infirmières autorisées dans un centre de naissance en Ontario et ayant travaillé au moins une fois avec une doula lors d'une naissance au cours des 20 dernières années. Les infirmières qui ont employé une doula pour leur propre accouchement peuvent participer.

Critères d'exclusion: les infirmières auxiliaires autorisées, les infirmières n'ayant jamais travaillé avec une doula et les infirmières qui suivent actuellement une orientation au Centre familial de naissance ne sont pas éligibles pour participer. Les infirmières travaillant à l'extérieur de l'Ontario ne sont pas éligibles à participer.

6. PARTICIPATION

Ma participation consistera essentiellement à une entrevue individuelle de 30 à 45 minutes, au cours de laquelle je serai interrogé(e) sur mon expérience et mes idées concernant la collaboration avec les doulas en milieu hospitalier. L'entrevue sera enregistrée sur audio avec un enregistreur numérique et sera transcrite intégralement à la suite de l'entrevue. L'entrevue sera organisée pour une date et une heure qui me conviendront entre octobre 2019 et septembre 2020. L'entretien sera réalisé via vidéoconférence Zoom. Les entrevues menées via Zoom seront uniquement enregistrées pour l'audio avec le même enregistreur numérique externe que les entrevues en personne.

7. BIENFAITS

Ma participation à cette recherche aura pour effet de permettre aux chercheurs d'explorer et de mieux comprendre la collaboration entre les infirmières qui offrent des soins intrapartums et les doulas en milieu hospitalier du point de vue des infirmières. Les résultats de cette étude fourniront des informations précieuses du point de vue des personnes impliquées et permettront de découvrir des thèmes et des déterminants qui influencent la pratique collaborative et qui peuvent ensuite être utilisés pour orienter les interventions visant à promouvoir une meilleure collaboration entre les infirmières et les doulas et permettra aux infirmières d'être mieux préparées à travailler en collaboration avec les doulas et les parturientes accompagnées d'une doula pourront mieux profiter de tous les bienfaits du soutien des doulas et du soutien des infirmières oeuvrant dans le domaine de la périnatalité

8. RISQUES

Au cours de l'entretien, je peux intentionnellement ou non :

- mentionner des noms d'individus

Je comprends que tous les noms et les informations identifiables que je mentionne seront omis du compte rendu. J'ai l'assurance des chercheurs que toutes les informations que je partage aves elles resteront strictement confidentielles, sauf lorsque requis par la loi.

9. CONSERVATION DES DONNÉES

Les données recueillies, les enregistrements d'entrevues numériques et les transcriptions des entrevues, seront conservées de façon sécuritaire. Les enregistrements audio d'entrevue seront conservés après leur transcription, car ils seront utilisés lors de l'analyse des données de l'étude en parallèle avec les transcriptions d'entrevue. Ils seront sauvegardés sur l'ordinateur portable protégé par mot de passe du chercheur principal et sur l'ordinateur du superviseur à l'École des sciences infirmières de l'Université d'Ottawa jusqu'à ce que l'analyse des enregistrements soit terminée. Les transcriptions imprimées ne contiendront aucune information d'identification. Tous autres documents physiques seront conservés dans le bureau verrouillé du superviseur (Université d'Ottawa RGN, salle 1118). Des copies de tous les documents seront conservées pendant 7 ans. Le système d'enregistrement interne de la vidéoconférence Zoom ne sera pas utilisé pour enregistrer l'entrevue. Un enregistreur numérique externe sera utilisé pour enregistrer l'audio des entrevues réalisées par conférence Zoom. Afin de participer à une interview par conférence Zoom sur l'ordinateur, je devrai suivre le lien Web unique que le chercheur principal m'a envoyé par courriel ou suivre les instructions relatives aux méthodes alternatives pour rejoindre l'entrevue en ligne qui m'ont été envoyées par courriel par le chercheur principal. Je peux utiliser mon prénom ou un pseudonyme lorsque je participe à la vidéoconférence Zoom, conformément aux instructions que le chercheur principal m'a envoyé par courriel.

10. CONFIDENTIALITÉ ET ANONYMAT

J'ai l'assurance du chercheur que l'information que je partagerai avec elle restera confidentielle sauf en cas d'obligation légale. Je m'attends à ce que le contenu ne soit utilisé que pour pour l'analyse de données qualitatives et selon le respect de la confidentialité. Mon histoire personnelle ne sera pas partagée avec mon supérieur immédiat ou mon employeur. La confidentialité est garantie de la façon suivante : Les enregistrements audios transcrits seront désidentifiés par un transcripteur professionnel. Les fichiers numériques des enregistrements et des transcriptions seront étiquetés avec la date et l'heure de l'entrevue et un code numérique. Une liste maîtresse contenant le nom des participants et les codes numériques sera conservée sous forme de fichier électronique dans un dossier distinct et

séparé des données de l'étude sur le portable du chercheur et sur l'ordinateur du superviseur à l'École des sciences infirmières de l'Université d'Ottawa. Seuls le chercheur principal et le superviseur auront accès à la liste principale. Seuls le chercheur principal, le superviseur de thèse et le membre du comité de thèse -Dr. Josephine B. Etowa- auront accès aux données démographiques désidentifiées et aux transcriptions des entrevues. L'autre membre du comité de thèse - France Morin- participera aux discussions sur l'analyse des données, mais n'aura pas accès aux transcriptions ni aux informations d'identification. Le transcripteur professionnel a signé un formulaire de confidentialité avant de commencer la transcription. Ceci étant, j'ai reçu l'assurance qu'aucun dossier m'identifiant, par exemple avec mon nom et mes initiales, ne sera autorisé à sortir du bureau du chercheur.

11. PARTICIPATION VOLONTAIRE

Ma participation à la recherche est volontaire. Je suis libre de me retirer en tout temps ou de refuser de répondre à certaines questions, sans subir de conséquences négatives. Pour me retirer de l'étude, je dois contacter le chercheur principal ou son superviseur par courriel (indiqué ci-dessus) pour les informer de ma décision de me retirer de l'étude.

Si je choisis de me retirer de l'étude, les données recueillies jusqu'à ce moment, incluant les enregistrements audios et les transcriptions subséquents, seront détruites, à ma demande. Les enregistrements audios et les fichiers numériques seront supprimés et les copies physiques des transcriptions seront déchiquetées.

Je serai informé en temps opportun si de nouveaux renseignements sont susceptibles d'affecter ma volonté de poursuivre ma participation à l'étude.

12. REMBOURSEMENT/INDEMNISATION

Je recevrai une carte-cadeau électronique de 10 $ pour Tim Hortons ou Indigo/Chapters (selon ma préférence) par courriel, en guise de remerciement pour avoir pris le temps de participer à l'entrevue.

13. COMMUNICATION DES RÉSULTATS

Je peux demander de recevoir par courriel une copie de la thèse finale de Gabriela M. Mizrahi, qui inclura les résultats de cette étude. Les résultats de cette étude pourront également être publiés dans des revues professionnelles et des conférences.

14. CONSENTEMENT

Acceptation : Je,_____, accepte de participer à cette recherche menée par Gabriela M. Mizrahi sous la supervision de Dr. Wendy E. Peterson. Pour tout renseignement additionnel concernant cette étude, je peux communiquer avec le chercheur ou son superviseur.

Pour tout renseignement sur les aspects éthiques de cette recherche, je peux m'adresser au Comité d'éthique de la recherche de [redacted], suite 102, à Ottawa, Ontario par téléphone [redacted] poste 2221 ou par courriel à [redacted]

Il y a deux copies du formulaire de consentement, dont une copie que je peux garder.

Signature du participant : Date :

Signature du chercheur : Date :

Dans le cas où le participant ne peut pas lire le formulaire de consentement (non-voyant, etc.) ou qu'il n'est pas apte à consentir (enfant, troubles cognitifs, etc.), il est nécessaire d'ajouter un espace pour la signature d'un témoin ou d'un tiers autorisé. N.B. Ne pas inclure cette section si ceci ne s'applique pas à votre projet. Si nécessaire, vous référer l'EPTC 2 pour plus de détails au Chapitre 3, *le processus de consentement* (p. 29-48).