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Midwives and doulas in Poland: mutual perceptions in the context of interprofessional cooperation[1]

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Abstract: A doula is an independent professional who provides emotional, physical and informational support to women during pregnancy, labor and the postpartum period. A doula is not medically qualified, but is trained in techniques to provide comfort, relaxation and proper breathing to women in labor during birth. The relationship between doulas and other members of the perinatal care team has an impact on women's satisfaction and the quality of care provided. The purpose of our study was to analyze the mutual perceptions of the two professional groups and to subjectively assess the actual cooperation between midwives and doulas; *Methods:* The survey instrument for examining mutual perceptions of midwives and doulas in the context of interprofessional collaboration was a self-administered questionnaire consisting of 13 items containing beliefs about collaboration between doulas and midwives and items describing experiences of collaboration between the groups. A total of 238 women participated in the survey: 165 midwives and 73 doulas. *Results:* Mutual perceptions of midwives and doulas can be described as positive or neutral. Examination of the experience of collaboration indicates a predominance of positive behavior. In almost all items, the beliefs of doulas and midwives differed significantly from each other showing the different perspectives of the two professional groups. The highest score in both groups was given to the statement Appropriate relationships between midwives and doulas have an impact on the satisfaction of parturients, which means that both doulas and midwives agree with it. *Conclusions:* There is potential for the dissemination of the doula profession in the Polish health care system. Both professions show more positive or neutral perceptions of each other than negative perceptions, which provides an opportunity to build a satisfying collaboration. The findings underscore the need to reconcile different attitudes in order to foster effective team practice and improve midwifery care outcomes. Training and meetings to learn about roles, competencies and explore each other's work models provide an opportunity to strengthen this collaboration.

Keywords: doula, midwife, collaboration, quality of perinatal care

Introduction

The World Health Organization stresses that midwifery midwives play a "critical" role and are linked to improving the quality of perinatal care. When midwives receive training that meets international standards, and their services include measures for broadly understood reproductive health, this can potentially prevent more than 80% of maternal deaths, stillbirths and neonatal mortality (Homer et al., 2014). To achieve this outcome, it is essential that midwives are formally certified, supervised, seamlessly integrated into health care structures, and work together in interdisciplinary groups (Shamian, 2014).

A doula is an independent professional who provides emotional, physical and informational support to women during pregnancy, childbirth and the postpartum period. A doula is not medically qualified, but

1 Article in polish language: https://www.stowarzyszeniefidesetratio.pl/fer/59P_BarB.pdf

is trained in techniques to provide comfort, relaxation and proper breathing to women in labor during birth. Her role is also to support the psychosocial aspects of childbirth, including providing emotional, informational and physical support and ensuring continuity of care (a doula usually gets to know the woman and the entire family during pregnancy, and accompanies her/him during labor and the postpartum period) (DOULA Association in Poland). The creation of interprofessional cooperation resulting from the combination of the professional competence of midwives with the competence and tasks of the doula, who can focus entirely on the psychosocial well-being of parturients, can be of great benefit to women and the perinatal care system (Goshomi, 2023). For this reason, a doula who accompanies a woman during labor should be viewed as a member of the therapeutic team (Turner et al., 2022)

Collaboration between midwives and doulas has been studied in terms of factors that enhance it, as well as barriers and difficulties. However, research has been conducted primarily in the United States, the United Kingdom and Scandinavia (Adams, Bianchi, 2004; Klein et al., 2009; Stevens et al., 2011; Waller-Wise, 2018). The results indicate, among other things, that midwives are concerned that doulas are encroaching on their role (Stevens et al., 2011). On the other hand, doulas who experienced conflicts with midwives explained these conflicts by the midwives' low understanding of their role and involvement and lack of confidence in their competence (Spiby et al., 2015). Very good cooperation between the two professional groups has been described in the case of women with special needs, such as migrant women and single mothers. In such situations, both doulas feel invited to collaborate and midwives feel truly collaborative and helpful (Akhavan, Lundgren, 2012; Khaw et al., 2023). Collaboration was described as very good by doulas who experienced genuine partnerships with midwives, in which they were welcomed as colleagues ("we're in this together") or effectively added to the midwifery team to help with specific tasks (McLeish, Redshaw, 2018). Midwives' favorability toward doulas increases along with their reluctance to medicalize childbirth (Klein et al., 2009; Roth et al., 2016). Thus, it can be said that cooperation between doulas and midwives is necessary and possible, but it can create challenges for both professional groups.

An optimal health care system is one in which there is an integrated system that supports professional partnerships, including those involving midwife and doula collaboration (Waller-Wise, 2018). The support of doulas can significantly complement the professional medical care of midwives, contributing to a more humanized birth process. Relationships between doulas and other members of this team affect women's satisfaction and the quality of care provided (Wojcik-Brylska, Pawlicka, Tataj-Puzyna, Szlendak, Węgrzynowska, et al., 2023).

In Poland, the first doulas began appearing in the labour room in 2001, and in 2015 "doula" was included in the list of professions. Currently, there are two associations with more than 200 doulas. Despite this, their presence in hospitals is not common. In Poland's medicalized and patriarchal system of maternity care, fostering a humanistic approach to childbirth would be highly beneficial. An analysis of the perspective of maternity hospital management staff in the Polish health care system showed that a lack of knowledge of doula roles and competencies, as well as a lack of collaborative experience, was associated with a negative perception of the profession and a lack of openness to such collaboration in the labour room (Wojcik-Brylska, Pawlicka, Tataj-Puzyna, Szlendak, & Baranowska, 2023). There are no studies describing and analyzing collaboration between doulas and midwives in Poland. There is also uncertainty about the place of doulas in the health care structure, but the growing interest in doula services among Polish families will result in more and more hospitals and health centers being forced to provide women with a choice and provide doulas with a place on the team providing perinatal care. The purpose of our study was to analyze the mutual perceptions of the two professional groups and to subjectively assess the actual cooperation between midwives and doulas.

1. Method

The research tool for investigating midwives' and doulas' perceptions of each other in the context of interprofessional collaboration was a proprietary questionnaire originally consisting of 25 items

containing beliefs about collaboration between doulas and midwives and items describing experiences of collaboration between the groups. The items were created by a group of professionals (2 midwives, 2 doulas and 1 psychologist) based on comments collected from midwives and doulas (in response to the question, What do you and other midwives/doulas think about collaboration between doulas and midwives?). In the next step, the initial items were evaluated by other experts (midwives, doulas, sociologist) in a 3-round Delphi and pilot process.

The final selected statements containing beliefs (13 items) were indexed as positively related to collaboration (Doula complements midwife's work; Doula is midwife's collaborator; Midwife has less work due to doula; Proper relationship between midwives and doulas influences satisfaction of parturients), neutral, but possibly suggestive of negative attitudes (Doula is an advocate for the women, Doulas earn more than midwives for care during childbirth) and negative beliefs and attitudes (Doulas do not take responsibility for their work; A midwife's building of a relationship with a doula puts additional strain on a midwife's time; Midwives have a poor understanding of doulas' tasks and their involvement during childbirth; Midwives lack confidence in doulas' competence; Doula is a challenge to the midwife's work; A doula undermines a woman's trust in a midwife; A midwife is burdened with additional work when she provides care together with a doula). The response options for each statement were on a 5-point Likert scale (from: totally disagree to totally agree). Both midwives and doulas responded to the selected 13 statements/items.

Items describing midwives' experiences in working with doulas included 9 statements, and items describing doulas' experiences with midwives included 8 statements. Responses were on a 6-point scale (never, very rarely, rarely, often, very often, always).

The hypotheses of the study were that midwives had negative attitudes toward doulas, that doulas had more positive attitudes toward midwives, and that the two professional groups recognized the relevance and importance of collaboration on the satisfaction of parturients.

2. Study group

The study included 238 women: 165 midwives and 73 doulas. The groups did not differ in terms of age (midwives' mean age was 40.7 and doulas': 40.5), educational level (88.5% of midwives and 86% of doulas had higher education), perceived economic situation (midwives: mean 2.15 (SD = 0.7) on a scale of 1 to 5; doulas: mean 2.36 (SD = 0.7)). The groups differed in terms of marital status (53% of midwives and 70% of doulas were married; 27% of midwives and 22% of doulas lived in a cohabitation, and 20% of midwives and 8% of doulas were single), place of residence (doulas lived in larger cities than midwives: 32% of midwives (and 16% of doulas) lived in rural areas and small towns, while 44% of midwives (64% of doulas) lived in large cities) and having children (58% of midwives and 93% of doulas had children). 50% of the midwives who participated in the survey had collaborated with a doula in childbirth (the average number of such births ranged from 11 to 15, but 34% had participated in 1-5 births with a doula), and 50% of these midwives knew whether the doulas participating with them in childbirth were affiliated with the DOULA Association in Poland. The average number of births attended by doulas was 15 (0 to 70; SD = 21.8; 26% did not attend a birth as a doula).

3. Results

3.1. Mutual perceptions of midwives and doulas in the context of interprofessional collaboration

Table 1 shows descriptive statistics on mutual perceptions of midwives and doulas. Each of the 13 items was analyzed separately. In addition, Table 1 shows the results of the ANOVA analysis showing the differences between the responses of midwives and doulas in each of the 13 questions.

The results presented in Table 1 show that in almost all items, the beliefs of doulas and midwives differed significantly from each other showing the different perspectives of these two professional groups (the exception is the question: Doula is midwife's collaborator, which was answered in a similar way

Table 1. Mutual perceptions of midwives and doulas

Item	group	N	Min	Max	M	SD	Standard error of the mean	F	p
Doula complements midwife's work	midwives	165	1	5	3.22	1.105	0.086	5.242	.023
	doulas	73	1	5	3.62	1.497	0.017		
Doula is midwife's collaborator	midwives	165	1	5	2.90	1.211	0.94	0.000	.995
	doulas	73	1	5	2.90	1.426	10.67		
Doula is a challenge to the midwife's work	midwives	165	1	5	2.70	1.118	0.87	22.001	< .001
	doulas	73	1	5	1.96	1.123	0.131		
Doula is an advocate for the women	midwives	165	1	5	2.82	1.239	0.096	20.959	< .001
	doulas	73	1	5	2.03	1.236	0.145		
Midwives have a poor understanding of doula tasks and their involvement during childbirth	midwives	165	1	5	2.79	1.219	0.095	38.750	< .001
	doulas	73	1	5	3.81	1.036	0.121		
Midwives lack confidence in doula competence	midwives	165	1	5	3.39	1.085	0.084	13.379	< .001
	doulas	73	1	5	3.93	0.991	0.116		
Proper relationship between midwives and doulas influences satisfaction of parturients	midwives	165	1	5	4.13	0.938	0.073	23.868	< .001
	doulas	73	1	5	4.71	0.612	0.072		
Doulas undermine a woman's trust in the midwife	midwives	165	1	5	3.11	1.153	0.090	117.125	< .001
	doulas	73	1	5	1.49	0.819	0.096		
Doulas earn more than midwives for care at childbirth	midwives	165	1	5	3.28	0.954	0.074	66.152	< .001
	doulas	73	1	5	2.12	1.130	0.132		
Doulas do not take responsibility for their work	midwives	165	1	5	3.47	1.217	0.095	122.159	< .001
	doulas	73	1	5	1.67	1.001	0.117		
Midwife has less work due to doula	midwives	165	1	5	2.90	1.146	0.089	16.530	< .001
	doulas	73	1	5	3.56	1.202	0.141		
A midwife's building of a relationship with a doula puts additional strain on a midwife's time	midwives	165	1	5	3.07	1.080	0.084	73.365	< .001
	doulas	73	1	5	1.84	0.865	0.101		
Midwife is burdened with additional work when she provides care together with a doula	midwives	165	1	5	2.93	1.118	0.087	104.136	< .001
	doulas	73	1	5	1.42	0.865	0.101		

by both groups). The highest score in both groups was given to the statement *The right relationship between midwives and doulas has an impact on the satisfaction of parturients*, meaning that both doulas and midwives agree with it.

3.2. Perceptions of cooperation with the other group

Additional questions in the survey focused on the experience of working with a second group. Respondents who had experience working with a second professional group were asked to rate the frequency of positive and negative doula/midwife behavior on a scale from 1 never, 2 very rarely, 3 rarely, 4 often, 5 very often to 6 always. Average scores for each question separately, as well as basic descriptive statistics, are presented in Table 2 and Table 3.

Midwives working with doulas most often appreciated the positive aspects of the collaboration, i.e., they reported that the doulas thanked them for their cooperation, seemed satisfied with the collaboration and were helpful to the midwives. In contrast, they indicated the rare and very rare presence of negative

Table 2. Experiences of midwives working with doulas in the labor room (n=62)

	min	max	M	SD
She exceeded her authority	1	6	2.87	1.29
Persuaded/encouraged, the women to refuse to cooperate with the staff	1	5	2.52	1.33
By her behavior/attitude expressed disregard for your work	1	5	2.60	1.36
Did not comply with the requests of the staff	1	5	2.72	1.37
Interfered with your work	1	5	2.67	1.26
Asked about the possibility of activities she encouraged the parturient to do (e.g., opportunities to use the shower)	1	5	3.74	1.20
She thanked you for your cooperation	1	6	3.76	1.42
She seemed satisfied with the cooperation	1	6	3.89	1.26
Provided assistance in your work	1	6	3.76	1.18

Table 3. Experiences of doulas working with midwives in the labor room (n=62)

	Min	Max	M	SD
She criticized/disregarded the methods you used	1	5	2.45	1.10
She was unkind, repulsive	1	5	2.55	1.20
She belittled, disparaged your work	1	5	2.69	1.08
She often asked you out of the delivery room	1	5	1.94	1.14
She took your opinion into consideration	1	6	3.66	1.12
She provided information	1	6	3.98	1.18
She seemed satisfied with your cooperation	2	6	4.16	0.99
Thanked you for your cooperation	1	6	3.45	1.50

aspects of cooperation, such as urging the parturient not to cooperate with staff, not complying with staff requests, or being dismissive of the midwife's work (Table 2).

The doulas also rated the experience of cooperation with midwives positively. They rarely or very rarely experienced negative behaviors such as being asked out of the labour room, criticized or belittled, while more often their opinions were taken into account by the midwives, the midwives gave them information, and they seemed satisfied with the cooperation. Detailed results are shown in Table 3.

4. Discussion

This is the first study in Poland to show how midwives and doulas view their professional groups in the context of interprofessional cooperation. The roles and tasks of these two professions differ and are precisely defined, midwifery – in the Act on the Profession of Nursing and Midwifery (Act of July 15, 2011 on the Profession of Nursing and Midwifery, no date), and doula – in the Code of Ethics for Doula Work Standards (Doula Code of Ethics – DOULA Association in Poland, 2019). In practice, however, there may be overlap in some areas of activity (e.g., a doula's provision of emotional support to a woman in labour is also essential to the care provided by a midwife) (Berg, Terstad, 2006) and the existence of mechanisms of interprofessional competition and rivalry.

Our survey showed that both professional groups were more likely to agree with statements indexed as positively related to collaboration between midwives and doulas than negatively. Both professional groups agreed with the statement that proper relationships between midwives and doulas have an impact on the satisfaction of parturients, which seems to indicate an understanding of the need for cooperation and the potential for proper cooperation in caring for women. This may be due to the alignment of the goal of the work, which is the health and satisfaction of the woman during the perinatal period. The doula's focus on the woman in childbirth is closer to the humanistic and holistic approach presented by midwives than the medical biomedical model of care. Research in Canada has shown that doulas consider midwives to be the most sympathetic professional group, and the midwives surveyed overwhelmingly showed a positive grounding toward doulas (Klein et al., 2009; Eftekhary, Klein, Xu, 2010). Stevenson's research further showed that despite antagonism,

both groups saw potential for collaboration (Stevens et al., 2011), and labor nurses surveyed in the United States agreed that doulas were important members of the maternity care team (Lanning et al., 2019).

At the same time, the results of our study indicated that the responses presented by the two professional groups differed. This may indicate a different perspective and difficulty in mutually empathizing with the actions of the other group. Doules were closer to stating that midwives do not know and trust their competence than the midwives surveyed. Findings from studies in Europe and the United States show that misunderstanding of the doula's role is common in midwifery circles, while emphasizing the importance of knowing each other's roles and competencies for smooth collaboration (Adams, Bianchi, 2004; Smid et al., 2010; Spiby et al, 2015; McMahon, Morris, 2018; Waller-Wise, 2018). Middlemiss (2015) showed that misunderstanding of the doula's role is a major potential for conflict. It can also lead to antagonistic attitudes toward the doula profession (McLeish, Redshaw, 2018), as well as tensions between midwives and doulas (Steel et al., 2013) and concerns about doulas usurping the midwifery role (Meadow, 2015; Middlemiss, 2015; de Carvalho Leite, Awoko Higginbottom, 2017). As the authors suggest, appropriate training can positively influence midwifery providers toward working with doulas. A training format that describes the doula model of care, defines doula roles, and strengthens doula relationships could support the effective integration of doulas into hospital maternity care teams (Neel et al., 2019). Greater exposure to each other during education can help create better positive interprofessional attitudes among midwifery team members (Klein et al., 2009).

The results of our study also show that midwives were more likely than doulas to believe that doulas are not responsible for their work. This may be due to the sense and awareness of midwives working in the labour room that they bear full legal and professional responsibility for the progress of the birth and the accuracy of the medical care process, are subject to strict standards of medical conduct and medical record-keeping requirements, and that the doula is doing her job, over which she defacto has no external control, and after the birth "goes home" without having to complete at least the birthing reports. From the doula's perspective, the "responsibility" defined in our study is arguably understood as a legal obligation between the doula and the client describing the reliability of the task performed (determined by a detailed service agreement signed between the doula and the woman). The midwives' understanding of responsibility in our study can thus be considered here in the context of medical responsibility, as described by Swedish women 'doula (...) has no medical responsibility'(Lundgren, 2010).

Our research also shows that it is midwives who are more likely to find that doulas attending births burden them temporarily and physically, and less likely to find that they have less work to do as a result of doulas. Research to date clearly indicates that midwives benefit from the presence of doulas in the labour room, although at the same time, the presence of doulas can be viewed by midwives as a challenge (Berg, Terstad, 2006; Akhavan and Lundgren, 2012). This may be due to a situation where the doula and midwife have worked together before and trust each other, in which case the doula can relieve the midwife in caring for the woman. If, however, this collaboration is just beginning, it often requires both parties to become familiar with the other's workshop, this generates additional time, which can be a challenge for overworked midwives (Ballen, Fulcher, 2006; Roth et al., 2016). Lack of trust, too, can cause midwives to need to frequently inspect the doula's work, or to fear the doula's judgment of her own actions.

Factors that influence differences in provider and midwife attitudes toward doulas range from personal exposure to individual preference (Lucas, Wright, 2019). Personal attitudes may have a greater impact on practice than existing evidence about the doula profession (Klein et al., 2011). For this reason, we explored not only beliefs and perceptions about collaboration, but also the experiences these professional groups had with collaboration. Midwives who interacted with a doula in the labour room agreed with the statement that the doula was a help to them. The majority of both midwives and doulas described behaviors that were positive and indicative of mutual commitment and

satisfaction (e.g., thanking them for their cooperation, being pleased with their cooperation, taking the other party's opinion into account). Doulas particularly appreciated being given information and indicated the rarity of frequent situations of being asked out of the labour room. Negative, cooperation-destroying actions such as criticism, undermining competence, etc. were shown to be reported as occurring rarely. In this context, it is also worth considering the specifics of the study group – whether the preponderance of mothers in the doula group, may have influenced their attitudes towards midwives. Research shows that being a mother, especially of a young child, is associated with higher levels of empathy, and thus may affect one's ability to put oneself in another person's place and see a situation from their point of view, and thus one's attitude toward them (Jin, Wu, Li, 2022).

Providing continuity of woman-centered care in an emotionally safe environment can ensure good collaboration between midwives and doulas (Siboulet, 2023). The positive potential for building effective collaboration, converging philosophies of care, and the skills of doulas and midwives to support women during labour and postpartum provide an opportunity for the introduction of interprofessional teams in the care of pregnant, birthing, and postpartum women.

However, a limitation of the study is the small number of respondents and the lack of clear verification that midwives' experiences were based on collaboration with certified doulas. Further investigation of midwives' experiences based on, for example, multiple collaborations with a particular midwife (which would help reduce the impact of an early, mutually demanding period of collaboration) could be of great importance.

Conclusions

There is potential for the dissemination of the doula profession in the Polish health care system. The two professions – doulas and midwives, show more positive or neutral perceptions of each other than negative perceptions, which provides an opportunity to build rewarding collaborations. The findings underscore the need to reconcile different attitudes in order to foster effective team practice and improve midwifery care outcomes. Training and meetings to learn about roles, competencies and explore each other's work models provide an opportunity to strengthen this collaboration.

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