
Breast milk and labour support: lactation consultants' and doulas' strategies for navigating the medical context of maternity care

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Abstract This article provides a comparison of two occupational groups working in maternity care: International Board Certified Lactation Consultants, who assist women with breastfeeding, and DONA International certified birth doulas, who provide physical, emotional and informational support to birthing women. Using interviews with 18 lactation consultants and 16 doulas working in the USA, I compare these two groups' strategies for gaining entrance to the maternity care team and their abilities to create change in maternity care practices. Due to the organisation of occupational boundaries in maternity care and differences between the influence of the medicalisation of breastfeeding versus that of childbirth on those boundaries, lactation consultants are able to utilise a front-door entrance to the medical maternity system, entering as lactation specialists and advocates, while doulas use a back-door entrance, emphasising their care work and downplaying their advocacy. These different strategies result in different methods being available to each for effecting change. Lactation consultants create formal change, such as changing hospital policies and practices to be more pro-breastfeeding. Doulas create change informally, 'one birth at a time', by creating space for natural birth to occur in the hospital, as well as exposing medical providers to non-medical ways of giving birth.

Keywords: childbirth, breastfeeding, medicalisation, professional boundaries, United States

Introduction

This article provides a comparison of two occupational groups in the USA maternity care system: International Board Certified Lactation Consultants (IBCLC) and DONA International certified birth doulas (CDDONA). In many ways these two occupations are quite similar. Their main function is to provide support to childbearing women. Lactation consultants provide breastfeeding support to nursing mothers and doulas provide emotional, physical and informational support to birthing women. They both work primarily within the medical maternity system, yet are providing support as part of an effort to reform maternity care. Lactation consultants work to promote and protect breastfeeding in order to build societal and medical support for breastfeeding women and a return to breastfeeding as the cultural norm, while doulas work to make birth more woman-centred and to end an over-reliance on medical interventions in childbirth. However, despite their similar histories and

goals of transforming maternity care, lactation consultants have gained more credibility and status in the USA medical context than doulas.

I investigate why this discrepancy exists through an examination of the context within which lactation consultants and doulas are working. I find that this context includes an interaction of two key factors: the system of occupational boundaries in maternity care and the contemporary medicalisation of breastfeeding, where breastfeeding is increasingly supported by medical professionals yet considered to be in need of medical management. These factors combine in order to create a complex landscape that opens up the medical system to lactation specialists and closes it to natural birth advocates. As a result, lactation consultants and doulas have each developed their own unique strategies for navigating this landscape and for gaining entrance to the medical maternity care team.

Thus the second issue I address is, given these different entry points to medical maternity care, what different methods are available to them for effecting change? An examination of these differences displays the power of the medical context of maternity care, while also illustrating how groups aiming to change maternity care are creatively able to carve out roles for themselves.

Lactation consultants, doulas, and medicine

While breastfeeding assistance and labour support are certainly not the exclusive domain of lactation consultants and doulas, these two occupational groups represent the largest groups of certified individuals doing this work in the USA (and both certifications are offered internationally, as well). Currently, there are 11,064 IBCLCs in the USA and an additional 1768 outside the USA (International Board of Lactation Consultant Educators [IBLCE] 2010). DONA International has over 5800 members in the USA and over 1100 members outside the USA including 2636 certified birth doulas (DONA 2010).

Both these certifications developed out of the natural childbirth movement and efforts to demedicalise childbirth and breastfeeding. The IBLCE created the IBCLC certification in 1985 with the help of La Leche League (LLL) International (IBLCE 2011), that supports 'natural childbirth, early bonding, exclusive and prolonged mother-child attachment through breastfeeding, and a child-centred family that respects each child's developmental timetable' (Blum 1999). The occupation was created in order to provide breastfeeding support and education that would facilitate a move away from mothers' and healthcare professionals' heavy reliance on formula and a return to breastfeeding as the cultural norm. Clinical research shows that receiving support from a lactation consultant increases breastfeeding duration and intensity (Bonuck *et al.* 2005, McKeever *et al.* 2002).

Doulas emerged from a grassroots movement in the USA, when women who wanted natural births began to have friends and childbirth educators accompany them during birth for support. The term doula, a Greek word meaning 'female helper,' was attached to the women working in these support roles, and doulas began to grow as an occupation (Norman and Rothman 2007). Doulas of North American (now DONA International) was founded in 1992 and was the first organisation to train and certify doulas (DONA 2005). One of the foundational concepts behind the development of the doula as an occupation was the recognition that labour support was integral to the achievement of natural birth (Morton 2002) and a number of clinical studies have confirmed that continuous labour support is linked to shorter labour and reductions in the rates of medication use for pain relief, Caesarean delivery and instrumental birth (Hodnett *et al.* 2011, Kennell *et al.* 1991).

For the most part, both lactation consultants and doulas perform their work in the medical system, working alongside healthcare professionals such as obstetricians, certified nurse midwives, paediatricians, neonatologists, labour and delivery nurse, and postpartum (or mother-baby) nurses. Lactation consultants work in a variety of settings, including hospitals, doctors' offices, clinics and community centres, and as private practice consultants helping breastfeeding mothers with the challenges of early breastfeeding and teaching and answering questions from new parents and healthcare professionals. Doulas provide emotional and physical support and serve as an informational resource on birth practices and procedures to women giving birth in hospitals, birth centres and at home. However, reflective of the fact that 99.1 percent of all USA births today occur in hospitals (Martin *et al.* 2010), most of their clients are giving birth in a hospital, either with a midwife or physician.

While lactation consultants and doulas share similar origins and both work within the medical maternity system, their strategies for gaining entrance to this system are dramatically different, due to the interaction of two factors. The first is the organisation of occupational boundaries within maternity care and the second is the different influences of the medicalisation of breastfeeding and childbirth upon those boundaries.

Occupational boundaries

Contemporary sociological scholarship on professions highlights the importance of the system of professions and the interactions and competition between professions in that system. As Abbott (1988) explains, professions must claim jurisdiction over an area of work by holding (or gaining) control over some form of abstract knowledge. Once a profession has gained such jurisdiction, they must defend it from neighbouring professions and other occupational groups in the division of labour. This is often accomplished through a process of occupational closure, where professions work in a variety of ways to exclude others from their area of expertise (Witz 1992). This is an ongoing process, where professions are continually defending their jurisdiction. This is complicated by the fact that the boundaries between neighbouring professions can never be strictly maintained, as there is always a bit of fluidity in the execution of tasks (Abbott 1988, Allen 1997, Svensson 1996). For example, Allen (1997) found that, despite nurses' accounts of strict boundaries between their work and the work of doctors, their day-to-day interactions represented a much more blurred nursing–medical division of labour. She found that nurses ordered blood tests and 'prescribed' additional intravenous fluid, even though medical diagnosis and prescription are the responsibility of doctors, not nurses.

Because of this fluidity, professions are constantly engaging in 'boundary work' (Gieryn 1983), defining and redefining the boundaries of their profession and working to distinguish it from other professions. Occasionally, external forces can create openings in the boundaries of professions. In medicine, these forces can range from formal governmental restructurings (Martin *et al.* 2009) to changes in the healthcare market (Mizrachi *et al.* 2005). In the medical maternity care system, changes in the medicalisation of breastfeeding have shifted occupational boundaries, creating an opening for lactation specialists.

The contemporary medicalisation of breastfeeding

Breastfeeding is a form of abstract knowledge and its medicalisation has made it a site of shifting occupational boundaries over the last century. During the early 20th century, medical professionals engaged in what Wolf (2000) has termed 'the social and medical construction of lactation pathology', where the quality and quantity of breast milk was brought into question. This abstraction of breastfeeding knowledge gave doctors jurisdiction over infant feeding (Apple 1987, Wolf 2000, 2001). Over the last decades, breastfeeding has been subject

to a different abstraction, led in large part by breastfeeding advocates, where it is now constructed as the gold standard in infant feeding, based upon the nutritional properties and health benefits of breast milk.

This approach has proved to be quite successful in gaining support for breastfeeding from the medical community. While there are most certainly many individual healthcare providers who are not supportive of breastfeeding, there are several professional organisations in medicine that have taken official pro-breastfeeding positions, including the American Academy of Pediatrics (2012), the American Congress of Obstetricians and Gynecologists (2003), the American Dietetic Association (2009) and the American Academy of Family Physicians (2008). Breastfeeding is also officially supported by the World Health Organization (2011).

This level of support for breastfeeding illustrates that this approach to breastfeeding advocacy has been instrumental in facilitating a move away from formula as the preferred method of infant feeding among medical professionals. However, it has not demedicalised breastfeeding. While breast milk is no longer constructed as an inferior product, the belief that breasts are likely to fail has not been reversed, and so the whole process is still perceived as being in need of medical supervision and management (Dykes 2005). Despite this perceived need, however, healthcare professionals (with the exception of midwives) receive very little training in breastfeeding and lactation (Feldman-Winter *et al.* 2008, Queenan 2011, Wolf 2006).

All these forces – the increasing medical support for breastfeeding, the call for medical management of breastfeeding, and the lack of breastfeeding training among medical professionals – have combined to create an opening for lactation specialists in the occupational boundaries of maternity care. This creates an opportunity for lactation consultants to claim jurisdiction over breastfeeding knowledge and fill this occupational space.

The medicalisation of childbirth

Childbirth is also a form of abstract knowledge, as its history of medicalisation illustrates. As in breastfeeding, childbirth was constructed as a medical condition or disease by obstetricians during the late 19th century, as they claimed jurisdiction over childbirth services and shifted women away from midwifery care (Wertz and Wertz 1989). Unlike breastfeeding, however, there has not been a major shift in the medicalisation of childbirth that has created an opening for doulas' advocacy of natural birth. Decisions about the course of a woman's labour fall squarely within the occupational boundaries of obstetricians, midwives and nurses. Norman and Rothman (2007) explain that, because of this, doulas are severely limited in their ability to act as advocates for their clients who want a natural birth. 'If a doula in a labor room or hospital delivery suite disagrees with the care provider or calls into open question what a midwife, physician, or nurse is doing, she can be asked to leave' (p. 263).

As a result of these differences in the contemporary medicalisation of breastfeeding and childbirth, the occupational structure of maternity care looks very different for lactation consultants and doulas, respectively. While lactation consultants are able to find an opening for their expertise, doulas find that their natural birth advocacy activates processes of occupational closure among maternity care professions. Doulas have had to find another entrance into the medical maternity system. In response to this, their strategy is to emphasise the continuous emotional and physical support that they provide to their clients; something that busy obstetricians, midwives and nurses are not able to offer in the hospital setting.

In this article I examine the strategies utilised by lactation consultants and doulas to navigate the occupational boundaries of the maternity care system and investigate what

impact these strategies have on their ability to create change. First, I describe the methods used to conduct this research, which formed part of a larger doctoral study.

Methods

The data for this article were gathered as part of a study of IBCLCs and DONA International birth and postpartum doulas. The analyses presented here are based upon interviews with the 18 IBCLCs and the 16 doulas who were working as birth doulas at the time of the interview. Because the focus of this article is an examination of how lactation consultants and doulas enter the medical maternity system, data from interviews with postpartum doulas, who very rarely interact with medical professionals, were excluded from the analyses.

The lactation consultants and doulas were recruited through contact lists of certified IBCLCs and DONA doulas retrieved from websites. The lactation consultant websites were International Lactation Consultant Association (n.d.), the professional organisation for IBCLCs, and Breastfeeding.com (n.d.) a website designed for breastfeeding women. The doula website was DONA.org. The lactation consultant websites resulted in a list of 31 lactation consultants and the DONA website resulted in a list of 34 doulas. Individuals were then contacted through their listed e-mail addresses. This method of recruitment resulted in 14 lactation consultant interviews and 16 doula interviews. An additional four interviews with lactation consultants and one interview with a doula were completed with individuals who were referred to the author by other participants in the study. Additionally, a local volunteer doula organisation sent a recruitment e-mail to members through their organisational e-mail list, consisting of approximately 70 active doulas. Not all doulas in this organisation are certified, and those who are certified are not all certified through DONA International. This method of recruitment resulted in three interviews.

The total number of lactation consultant interviews was 18. Ten were working in a hospital, two worked in private practice, three worked in both settings and three worked in other settings. The total number of doulas interviewed was 20. Of the 20 doulas, 12 were working as birth doulas, four were working as postpartum doulas and four were working as both. The four doulas working only as postpartum doulas have been excluded from the present analyses. Therefore, the final sample size for the analyses presented here was 34 participants. All participants were given UD\$20 in exchange for their participation. The Institutional Review Board of the University of Michigan approved this study and informed consent was obtained from all study participants.

The average age of all participants was 47.8 (SD = 12.1), with the average age of lactation consultants at 53.9 (SD = 8.9) and the average age of doulas at 41.0 (SD = 11.8). All participants were women. The study sample was mostly white ($n = 30$), with one African American lactation consultant, two African American doulas and one multiracial/biracial doula. One of the doulas had a high school diploma, 11 of the participants had completed some college (lactation consultants = 3, doulas = 8), 17 had a college degree (lactation consultants = 11, doulas = 6), and five had a graduate degree (lactation consultants = 4, doulas = 1). The average number of years since receiving the IBCLC certification was 11.9, with a minimum of two and a maximum of 21. The average number of years since receiving the CDDONA certification was 5.4, with a minimum of two and a maximum of 10.

The two most common pathways to the IBCLC certification are through experience as a registered nurse (RN) or as a LLL leader. This trend was reflected in the sample for this study. In all, 14 lactation consultant participants were nurses, eight were LLL leaders (five

were both) and one was neither a nurse nor a leader. There was quite a bit of variation in the relationship between the respondents' background and work setting. One may expect that lactation consultants working in hospital settings are RNs, but two in this sample were not, and four who were RNs also had a background as a LLL Leader.

Lactation consultant interviews were conducted between April and July 2008 and the doula interviews were conducted between January and March 2011. During the interviews I asked participants about their background and certification process, their work as a lactation consultant or doula, and their views on breastfeeding (lactation consultants) and childbirth (doulas). The interviews were semi-structured and all were audio-recorded. They were approximately an hour in length, with a range of 34 minutes to 2 hours and 11 minutes. The participants also filled out contact information and a short questionnaire. While there is no reason to believe that the participants in this study vary from the population of lactation consultants and doulas in the study area in any systematic way, there is tremendous variation across the USA and internationally in the context in which lactation consultants and doulas work. Therefore, caution should be used in generalising from these data.

All interviews were transcribed verbatim. The analysis was conducted through a process of open and focused coding, as described by Emerson *et al.* (1995). First, code categories were identified through systematic open coding. Then, through a process of memoing, these codes were analysed for patterns and organised into core themes, which were then broken down into subthemes through focused coding. The quotes presented here are representative of the data in each theme or subtheme from which they were chosen. The following analysis presents the lactation consultants' and doulas' reports of their work, focusing on their interactions with hospital staff and examining how their strategies for navigating occupational boundaries affect their approaches to creating change in maternity care.

Findings

Lactation consultants: entering through the front door

The lactation consultants I interviewed reported being accepted as lactation specialists by most of the medical staff. While many of the lactation consultants in this study did have stories about doctors or nurses who did not support breastfeeding and who resisted the lactation consultants' presence, overall, their reports indicated a fairly high level of organisational support and respect from medical professionals. There were several aspects of lactation consultants' descriptions of their interactions with medical staff that indicated their status as lactation specialists. Two of the more salient examples were clinicians deferring to lactation consultants' breastfeeding knowledge and the role of lactation consultants in educating hospital staff on breastfeeding.

One area of breastfeeding knowledge where lactation consultants described being regarded as experts is the contraindications to breastfeeding, especially in the case of medications. Some lactation consultants reported being the physicians' source of information on combining breastfeeding with certain medications, despite the fact that the lactation consultants themselves cannot prescribe medicine:

Mothers are on so many medications now that, that's the part I don't enjoy, but it's a huge part of my job, trying to figure out, you know, even though it's not my call to make, it's not in my realm of what I can do. I can't say, 'yes you can still breastfeed.' It's the doctor, they just ask me and they say whatever I say. (Denise)

Another aspect of lactation consultants' descriptions of their work that illustrates their acceptance as breastfeeding experts is the breastfeeding education they provided to clinicians, including doctors, residents and nurses. Sometimes, this education was formal:

Immediately when I started this they wanted all the [registered nurses] to go with us for 4 hours each, so they could see what we tell [the moms] and see what we show [the moms].... The management wants them to be able to handle things when we're not there, you know. So, they want us to teach them as much as we can. (Alice)

At other times the education was informal, as Carol explained:

Um answer questions doctors have. Um talk to the nurses, you know, ki-, kinda always on the job teaching because no matter how much you teach or offer classes, there's such a knowledge deficit among people.

These reports of being asked to educate staff, particularly the doctors and residents, illustrate the respect for lactation consultants' knowledge that exists in the hospitals. Lactation consultants' reports of their interactions with healthcare staff indicate that they are using what I term a front-door entrance to the maternity care team, where they enter as lactation specialists and are incorporated in the medical team in a manner that looks much like a coordination of care. For example, lactation consultants often indicated receiving new clients through referrals from clinicians. Susan, a hospital lactation consultant explained:

We get referrals from the nurses or from the patients themselves if they ask to see us or if there's clearly someone who's not doing well, then they get onto our service, our list.

It was not just the hospital lactation consultants that reported receiving clients through referrals. Angela, a private practice lactation consultant, said:

I would say about half of [my clients] are a referral from a paediatrician who gives my name out and the other half are varied, but people get lists from hospitals and childbirth classes.

Receiving clients through referrals initiates a coordination of care where the lactation consultant is incorporated in decisions about their breastfeeding clients' care. According to hospital lactation consultants, when they received a referral from a doctor or nurse, that staff person gave them all the information about what had happened so far. After they worked with the women, they reported, either verbally or by charting, what happened and what the status of the situation was. This coordination of care was explained well by Nancy:

Um, well, I – it really should be a team approach. Um, I don't necessarily need to contact the physicians to let them know how things went, but on the referral sheet that I have, it's checked off when I've noted the referral and when I've seen their patients. A lot of time physicians will indicate that they need the baby seen prior to discharge. So, um, and if I happen to see them in the hall, they may wanna speak with me and ask me how things are going, for particular cases that are more challenging. (Nancy)

Lactation consultants working in private practice indicated that they coordinated care of their clients similarly. If they received a referral from a physician, they often sent a report to the physician's office after they had seen the mother.

Lactation consultants: creating formal changes

When lactation consultants enter the maternity care system through the front door as lactation specialists they are able to create formal changes around breastfeeding. Their descriptions of their work included numerous references to situations where they created changes in policy and practice. Lactation consultants reported creating formal changes in hospitals, organisations and the community through their membership on boards, committees and coalitions:

I did start a breastfeeding task force and I do have a paediatrician and obstetrician on our board, as well as a pharmacist and a few nurses ... I mean there was nothing at this whole hospital and it took us a year to get all the breastfeeding policies written and approved because there is a lot of stubborn physicians. I mean breastfeeding is not an issue. It's not a priority at all to the doctors like it is to me. (Paula)

Despite the fact that Paula did face some opposition from doctors at her hospital she was able to create formal changes in support of breastfeeding. Similarly, Sharon explained how she and a fellow lactation consultant, who both work as independent consultants, were 'doing a milk depot' for an area hospital, where women could donate their extra breast milk and then physicians could prescribe the breast milk to babies in need. Lactation consultants also described changes made through the education they provided to healthcare professionals. They described teaching physicians, residents and nurses about the benefits of breastfeeding and how to best support breastfeeding women. They also explained how they worked toward eliminating misinformation, often about contraindications to breastfeeding that could lead a doctor or nurse to tell a woman to stop breastfeeding when she did not need to:

And they would, somebody, I don't know if it was a radiologist or someone, but somebody was telling the mothers they had to, dump their milk, pump but dump their milk for 24, 48 hours. And the research shows that that's not accurate, so it's taken a while to get that message across, and we haven't had a case in a few months here. So, that – that just took a while, contacting different people, and, over and over again, giving them the information, telling them, 'No these moms don't have to be pumping and dumping.' (Sandra)

While lactation consultants are utilising a front-door entrance to the maternity care system and creating formal changes in support of breastfeeding, the situation is quite different for doulas, because there is no occupational space for natural birth advocates in the medical maternity system.

Doulas: entering through the back door

The doulas told me that the hospital staff does not defer to doulas and almost never asks them their opinion. Only one doula mentioned being asked by a physician what her opinion was, and this respondent was also a midwife and had been a doula for 10 years. While doulas did report that midwives are more accepting of the doula role, only two individuals described being included in decisions by midwives. Altogether, only six doulas made any comment at all that suggested they were respected as knowledgeable. In addition, doulas did not report

having the opportunity to educate medical staff like the lactation consultants did. In fact, Christy said that she would like to teach the staff, but does not feel like she is in a position to do so:

I think about it, and I'm like, the nurse that was saying that it was actually better to be in the [radiant] warmer versus [skin to skin] on the mom, I'm like, you know, 'Would it be good if I had like a handout that – ' but I mean obviously she might be insulted by that and so I don't know what the best way to get her that information is but I don't feel like she's purposely being mean. I don't feel like she wants something bad to happen to you or she wants to separate you from your baby. You know, I feel like she's trying to do a good thing and she just doesn't have the right information. So I don't know that there's any way for me to train her or to, you know, I wish there was something else.

Because doulas' knowledge of the scientific literature is not recognised, Christy did not feel that she had a way of sharing this information with hospital staff. In this context where they are not regarded as experts or specialists by hospital staff, doulas' descriptions of their work rarely included a coordination of care with healthcare professionals. First of all, doulas seldom mentioned receiving referrals from healthcare professionals. Most often, their clients found them through websites, whether it was the DONA International website, their own website or another website that offered a directory of local doulas.

Also in contrast to lactation consultants, doulas did not report being asked to coordinate care by consulting with medical staff about patients or providing staff with reports of their interactions with their clients. This was not due to a lack of information to report. Because doulas are with their clients continuously, they often described their very holistic understanding of their clients' labour progress:

Like the care providers might see that there's only been a centimetre of change in 4 hours so they are starting to worry about the wellbeing about this mom and baby. I have seen that in those 4 hours she had been moving along and the nurse came in and asked her about her previous birth experience and she told this traumatic story and then pretty much pittered out [slowed down] and stopped for an hour and a half. And then she got in the tub and relaxed a little bit and they started trickling back and for the last half hour things have been going well. In my mind, we had a stall that we got through and now we have made a centimetre of progress in 30 minutes. This labour's fine. (Meredith)

Despite this level of understanding about the labour, doulas almost never reported being asked about it by clinicians, underscoring the fact that they are not regarded as having valuable information about labour progress. Another factor that may be at play here is the similarity between doula work and a midwifery model of care (Rothman 1982). Meredith clearly values a holistic understanding of labour, which the care provider for this labouring woman may not.

As in Norman and Rothman's (2007) report, doulas' exclusion from a coordination of care is so strong that they often reported feeling unable to discuss birth procedures with medical staff for fear of being labelled as a 'bad doula', who staff believe are combative and challenge medical birth despite the health of the mother and baby. The threat of the 'bad doula' represents well the difficulty that doulas face in advocating for their clients. Even when they are not openly challenging medical staff, they are assumed to be working against the hospital. As Meredith put it, 'I definitely think they see doulas as people who are anti-the medical establishment'.

Because doulas cannot find entrance into the maternity care system as natural birth advocates, they are entering as supportive labour companions, a strategy that I refer to as a back-door entrance. The support doulas provide includes things such as changing pads, taking the mother to the bathroom, changing the bedding, holding the mothers' hands, keeping mother and father calm and relaxed, massaging, holding a leg during pushing and walking around with moms. As doulas explain, the clinical staff does not provide much emotional and physical support. If they do, it is done by the nurses, but the nurses have so many demands on their time that they do not have the time to provide the level of support that the doula can:

Sometimes those nurses are running themselves crazy trying to keep up with two moms who are full on labouring and – and that's – there's no way they can spend time holding people's hands and, you know, helping them get to the bathroom every time and, you know, stuff like that. (Michelle)

Doulas explained that, for this reason, medical staff is often glad to let doulas provide this type of support.

Doulas: creating change 'one birth at a time'

Once doulas have utilised their labour support role as a back-door entrance to the maternity care team, they use this position to resist medical birth in a number of ways, creating change 'one birth at a time'. Doulas described themselves as an informational resource to their clients, who can help them understand the benefits and drawbacks of particular procedures that may be offered or suggested by the medical staff during birth. As Danielle explained, 'Um, once everybody has left, then I will give them the pros and the cons, um, and then I leave the decision-making up to them'. They also reported making sure their clients recognised when a medical procedure was about to be performed. As Kelly explains:

I am the one who puts the pause for the cause in there and who says, 'Yeah, okay, so they want to rupture your membranes'. And they're standing there holding the amnio hook between your legs and you really haven't given them consent but they're going ahead and doing it because nobody's said, 'Okay, so wait a minute. Is this important to do right now?' And I'll – I'll – that – and that's what I say to the families. 'Do you have all of your questions answered in terms of this rupturing of the membranes?' And that's – that's then to pre-established language that this client and I have come up with is my buzz way of saying, 'You might want to ask your questions now'. And if they turn to 'em and say, 'No, I'm comfortable with what's going on', I'm like, 'Excellent. I just wanted to check in with you'.

These types of subtle advocacy are in line with what Norman and Rothman (2007) found. However, for the doulas in this study, their advocacy went one step further. Once doulas gained acceptance into the maternity care team through their care work, they sometimes found room for trying alternative methods of managing labour complications that would otherwise be solved by medical intervention. Brenda described an incident where her client was fully dilated but the baby was having difficulty moving past the pelvic bone. The doctor suggested they use the vacuum. Because her client did not want to do that, Brenda asked the physician if she could try using a rebozo, a long rectangular cloth, to hold up the abdominals while her client did a couple of pushes.

And, um, so when I said to him, 'Will you please just let her get out of bed and let me just try this one thing on her'. Now I couldn't do this to all doctors but this one I have a relationship with and I could do that with. And so he said, 'Um, I'm going to go down to the nurse's station for a few minutes'. And so I said, 'Okay, okay'. And so she jumped out of the bed and we got into this position and Mom was on the floor holding the perineum and I had got her strapped in this contraption and her husband's in front of her and it was so cool because, um, a couple of the nurses for whatever reason, they just stayed hands off and they stood back by the door and they were just watching this. They weren't running up there checking the monitor, you know, trying to put her on a monitor or anything. It was just amazing. And she had three contractions where she pushed like that and the mother was like, 'The head – the head's coming out!'

This aspect of doulas' interactions with medical staff suggests that, while they may not be considered experts or specialists like lactation consultants, they may be transitioning to what Mizrahi *et al.* (2005) called 'cautious approval' (p. 26) to describe biomedical practitioners' partial recognition of the usefulness of alternative medicine. Doulas are allowed to try something alternative for a certain amount of time because 'there is good reason to believe that it 'could do no harm''.

These methods of resisting medical birth are not creating formal changes in policy and practice, as lactation consultants are able to do. However, with each of these acts of subtle resistance, they are illustrating to medical professionals that women can give birth without medical intervention, and they are exposing clinicians to different ways of giving birth and are creating change, 'one birth at a time'.

Some doulas discussed seeing changes in the hospitals as a result of their work, finding that medical staff acts differently when they are present. For example, Kelly stated that a nurse told her, 'The – the nursing staff behaves better when there's a doula in the room'. Others felt that staff is often more supportive of their clients' wishes when they have a doula. Brenda even stated that she is so well known at her community hospital that her clients do not have to go through triage in order to be admitted in most cases.

And then usually, uh, at this hospital unless somebody thinks their water has broken but they don't know for sure, we usually can avoid triage and go right to the room. They know that I have – they trust what I am doing and they have seen proof of what I have – I am doing so, um, pretty much when Brenda calls and says, 'I have somebody in labour. We're heading up,' they know that it's usually the real deal'.

These examples show how some doulas are creating tangible changes in the practices of clinical staff. One thing illustrated here is that the changes doulas are able to make rely upon healthcare practitioners having consistent positive interactions with doulas and their clients. Some of the participants, like Tamara, who have been doulas for a long time, discussed the changes that they have seen since beginning this work:

Like I said, 10 years ago, it was harder but, you know, I think that if an OB has do – been doing their job long enough, they have met a few doulas, um, and I think that again, some of them are singing our praises'.

This would suggest that as doulas continue to grow in numbers, and more and more women hire them to attend their births, the impact of doulas on hospital and birth practices will grow as well.

Discussion

Lactation consultants and doulas have similar origins in the natural birth movement and they are both working to transform maternity care. Despite these similarities, the differences in how they described their positions on the maternity care team indicate they are utilising drastically different approaches to gaining entrance to the US maternity system. Because breastfeeding has become medicalised in a way that emphasises breast milk as the superior infant food, it has been able to gain the support of many medical professionals and organisations. However, when considered a medical product, breast milk administration needs medical management. Because healthcare professionals receive very little training in breastfeeding, this has created an occupational space for lactation specialists on the maternity care team. Lactation consultants are using the strategy of filling this space, giving them a front-door entrance to the medical maternity system as lactation specialists working formally in their advocacy role.

Doulas, on the other hand, cannot find an occupational space in medicine as natural birth advocates because their advocacy challenges the occupational boundaries of maternity clinicians. Within the context of these clashing boundaries, it is highly unlikely that doulas, whose training is much less rigorous than that of clinicians, and who are not qualified to provide medical care, could enter the medical maternity system on the basis of their expertise in childbirth. It is even less likely that they could then be accepted as birth advocates. Doulas are thus using a strategy of entering the system on the basis of the support they provide to clients. This allows them to present themselves as working together, as part of the maternity care team. While the support that doulas provide is an important part of their work, this has also served as a back-door entrance to the medical maternity system that has allowed them to resist medical birth and create space for natural birth to occur in the hospital.

These two different methods of entry determine the way these two occupational groups approach the need to change medical practice. Lactation consultants reported being able to effect change in formal and direct ways, such as changing hospital policies to be more pro-breastfeeding or educating medical staff on breastfeeding and how to support breastfeeding women. Doulas, because they are not given the status of expert or specialist, are not able to effect change in formal or direct ways. However, they described other ways they make a difference, such as creating space for natural birth in the hospital by helping their clients to recognise and understand medical procedures when they are presented by the staff. They also indicated that, as medical professionals work with doulas more and more, they are making subtle changes in the birthing room. Staff may be more cognisant of what they do or say; they may be more supportive of the woman's wishes and, in some cases, they may even allow the doulas to try alternative methods of helping labour progress. Doulas are also exposing medical providers to natural birth, showing them what birthing women are capable of doing and helping providers step outside of their comfort zone to assist natural births. While these changes are not formal in the way that a breastfeeding-friendly hospital policy is, they are still very meaningful.

This article has provided a sociological examination of two groups that are nearly non-existent in social scientific research. As two relatively new occupations working towards change in maternity care, lactation consultants and doulas offer a unique glimpse into the maternity care system. These occupations are growing rapidly, both in the USA and internationally, which means they are going to have an increasing presence in maternity care.

It is therefore important for researchers, and the caregivers themselves, to understand their role in the maternity system. This study is a first step in this direction.

This research also contributes to our continually evolving understanding of jurisdiction and occupational boundaries, particularly in medicine (Abbott 1988, Friedson 1970, Larson 1977, Martin *et al.* 2009, Mizrachi *et al.* 2005). It illustrates how different aspects of the same process – the medicalisation of maternity – have created distinct openings in the occupational structure for lactation consultants and doulas. Furthermore, this research extends the concept of occupational boundaries by demonstrating how this framework can be used to examine the methods of social change that are available to occupational groups.

We need further in-depth studies of the professional projects (Larson 1977) of these two groups and how these projects affect their work. How do lactation consultants work to present themselves as lactation specialists? Having used the medicalisation of breastfeeding in order to enter the medical system, how does this shape their interactions with breastfeeding women? How do doulas gain respect in the birthing room when they enter the medical system through the low status position of a support companion? Future research should also examine the impact on professionalisation of differences at the organisational level by studying the certifying agencies. The IBCLC certification has more stringent requirements than the CDDONA certification, including more coursework, more contact hours (assisting breastfeeding women) and an examination. While these differences are not significant enough to override the impact of the social context of maternity care examined in this article, they certainly warrant further investigation.

It would also be useful to study these occupational groups *in situ*. Allen (1997) found in her study with nurses in the UK that researchers sometimes find discrepancies between what participants say and what they do, especially when they are working to define their occupational boundaries. In this case, as lactation consultants work to define themselves as lactation specialists, it is likely that they would describe their interactions with healthcare staff as mostly respectful of their knowledge. Similarly, because doulas' labour support work provides the best opportunity for them to join the maternity care team, they are likely to describe this work as well-received by medical staff. Participant observation of lactation consultants' and doulas' work would provide an examination of their interactions with healthcare staff and clients in order to study the perspective of all parties involved and to see their advocacy work in action.

Finally, because the IBCLC and CDDONA certifications are international, and because there are similarities between the medical maternity system in the USA and other industrialised countries, it is likely that the results presented here are applicable to those outside the USA. However, there are undoubtedly important cross-cultural differences that should be examined in future research.

In summary, this research illustrates how the process of medicalisation can create shifts in occupational boundaries so that seemingly similar occupational groups may find completely different openings and closures. Furthermore, it has demonstrated how strategies for navigating these boundaries can have a profound effect on the methods of social change available to each. In doing so, it displays the power of the medical context of maternity care, while also highlighting how groups working towards change are able to carve out roles in the maternity system.

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Notes

- 1 All names of participants used in this article are pseudonyms.
- 2 For the purposes of this article, the term 'lactation consultant' refers to IBCLCs only and the term doula refers to DONA birth doulas only.

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