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Credentialing Care: COVID-19 and the Bureaucratization of Doulas

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Abstract:	Doulas in the United States offer embodied, informational, and continuous one-on-one care to birthing people. Doulas have historically sought certification to gain knowledge through training and to gain legitimacy for healthcare providers and clients. During the COVID-19 pandemic, hospitals required doulas to provide proof of certification. The COVID-19 pandemic, and the proliferation of state-sponsored doula programs, has sparked a shift in how doulas are viewed and regulated, enabling new forms of bureaucratic oversight and control. Based on participant observation, surveys, and semi-structured interviews, we examine the connection between certification and care including motivations doulas have for certification, the perceived value of certification, certification as a form of gatekeeping, and increased bureaucratization of doulas. Using a critical feminist approach, we argue that increased bureaucratization and surveillance of doulas has not improved standards of care or led to more equitable access. Indeed, doulas provide a window into the negative impact of bureaucratization on care. While some of these negative impacts are byproducts of policies intended to increase oversight and access to doula care, we argue that increased bureaucratization and surveillance of doulas is also intended to act as a gatekeeping mechanism demonstrating how policies contribute to uneven reproduction (Davis 2023).

Credentialing Care: COVID-19 and the Bureaucratization of Doulas

In the United States, doulas provide continuous physical, emotional, and informational care to help birthing people through important life transitions. Doulas have no clinical training and are non-medical professionals, but a growing body of research suggests that the presence of a doula supports physiological birth and healthier outcomes for mothers and babies (Bohren et al. 2017; Hodnett et al. 2013; Hodnett 2002). Awareness and use of doulas for birthing support is increasing in the US (Guenther, Kett, and Frogner 2022; Declercq et al. 2014; Hodnett et al. 2013) especially as the deep disparities in maternal mortality become alarmingly visible through increased activism and media attention (Taylor et al. 2019; Martin and Montagne 2017). US policymakers have begun calling for doulas as a solution to address reproductive inequities (Sobczak et al. 2023). Despite this increasing awareness of the value and benefits of doula care, the nature of care provided by doulas is undervalued and not well understood (Turner et al. 2022). Doulas have long held precarious and liminal positions in hospitals, occupying a space Everson and Cheyney describe as "between two worlds, suspended in limbo" (2015, 2006).

Prior to the COVID-19 pandemic, doulas experienced varying degrees of indifference and hostility in clinical settings, but rarely did hospitals or states attempt to regulate or legislate their presence. COVID-19 sparked an exclusionary shift in how doulas were viewed and regulated, as they were barred from clinical spaces and deemed non-essential workers. The pandemic enabled new forms of bureaucratic oversight and control over doula care, many of which have remained in place. Hospital policies during COVID-19 required doulas to provide certification to enter, and created arbitrary and widely varied lists of certifying organizations that were accepted for entry. These requirements interrupted doulas' capacity to provide continuous care for families. Such exclusions did not come as a surprise to doulas, who have long felt

unwelcome in some clinical spaces, both because of their increasing role as advocates for historically marginalized birthing people and because doulas support autonomy in birth that can run counter to the assembly line approach to birthing many hospitals prefer. Yet in some ways, doula care has been highlighted and supported by policy makers and some healthcare institutions. These institutions have focused their attention on rising maternal mortality rates in the United States and in the past decade, several states, including Oregon, Minnesota, New Jersey, and Rhode Island, have adopted policies intended to extend access to doula care by allowing doulas to be reimbursed by some state-sponsored and private insurance companies (Kozhimannil and Hardeman 2016; National Health Law Program 2023). However, these policies often require doulas to be certified and specify which certifying organizations make them eligible for reimbursement. Reimbursement requires doulas to spend significant time seeking authorization by Medicaid, translating billing codes, submitting payment forms, and other bureaucratic tasks, all with very little guidance from state agencies (Chen 2022). These gatekeeping policies are a form of bureaucratic control that attempt to regulate and define doula care, and doulas must reckon with the role state and the obstetric institutions play in defining their scope of practice. From doulas' perspectives, medical systems and policymakers do not understand the nature of their care work or the differences between various certifying organizations and therefore have no business playing a regulatory role.

In this paper, we explore how the COVID-19 pandemic amplified pre-existing bureaucratic pressures on doulas, including an increasing emphasis on certification, in ways that both challenge and change care practices. This research is part of an ongoing project that includes a large qualitative survey of over 500 doulas in 2020 during the initial months of COVID-19 as well as 60 semi-structured interviews with doulas working in the US from May of

2022 through April of 2023.[1] While certification processes may at first glance seem abstracted from doula care, the bureaucratic constraints placed on doulas from hospitals and insurance companies can have a significant and often detrimental impact on the care doulas provide. We examine the motivations doulas have for certification, the perceived value of certification, certification as a form of gatekeeping, and increased bureaucratization of doulas. We argue that increased bureaucratization and surveillance of doulas has not, in fact, improved standards of care or led to more equitable access or care practices. Instead, the move towards increased bureaucratization and regulation around certification requirements has decentered care and narrowed who is able to provide care. While some of the negative impacts on doula care is merely a byproduct of policies intended to respond to the perceived need to manage an increasing number of doulas attending hospital births, the negative impact on doulas and the care they provide is not merely accidental. Rather, the increased bureaucratization and surveillance of doulas is part of what Dana Ain-Davis calls uneven reproduction, as she draws our attention to the "complex patterns of investment and disinvestment that reconfigure reproduction" (2023).

Certification and the Bureaucratization of Care

Birth workers, often in the form of granny midwives and other birth companions, supported births in their communities long before the emergence of the doula movement (Oparah and Bonaparte 2015, Craven 2010, Susie 2009, McGregor 1998). This is particularly true in marginalized communities, especially during slavery, where reproductive care from community birth workers was central to communities' very survival (Morgan 2004, McDonald 1997). These community birth workers were never known as doulas, even though the care work they

[1] Semi-structured interviews lasted between forty-five and ninety minutes. Interviews were conducted over Zoom by our research team. The doulas directly quoted in this paper were part of the interview data collected in 2022-2023. All findings were analyzed using Dedoose and coded using standard group coding protocols (Bernard, Wutich, and Ryan 2016). All research activities were IRB approved. All names used are pseudonyms.

performed was similar. In the nineteenth and early twentieth century, the emerging field of obstetrics denigrated and criminalized the expertise and care community birth workers offered, targeting Black midwives, in an effort to establish obstetric medicine as the standard for birth (Fraser 1998, Wilkie 2003). This history is important in considering the emergence of doulas and their relationship to the field of obstetrics and biomedicine as it provides context for the racialized history of birth workers and the challenges doulas would face. Doulas emerged in the US in the 1970s and 1980s as a response to the overmedicalization of births (Morton 2014, Gilliland 2002). The US medical system relies on obstetricians with a technocratic approach to birth rather than midwives who offer a holistic approach (Davis-Floyd and Cheyney 2019). People sought out the holistic and emotionally responsive care of doulas to push back against a medicalized model of birth and to ensure individualized continuous care during labor and beyond. Doulas provided a "woman-centered response to the need for emotional and informational support during this significant life transition" (Morton and Clift 2014, 99).

While doulas were informally supporting birthing people in the 1970s onwards (Raphael 1976; 1981), professional doula organizations only began to form in the 1990s. The largest such organization, Doulas of North America (DONA), which later became DONA International, was founded in the United States in 1992 by a group of childbirth educators and physicians (Searcy and Castañeda 2022). As birth workers recognized the positive impact continuous emotional and physical support could bring to people in labor, more women came to work as doulas, and professional organizations rose up to create opportunities for training and certification. The professional doula movement was founded by and served an overwhelming majority of women who identified as white, cisgender, heterosexual, married and college educated (Guenther, Kett, and Frogner 2022, Lantz et al. 2005; Kozhimannil et al. 2013). As the movement has expanded,

its participants have diversified, including a push towards expanding the role of community doulas who support specific socioeconomic, racial, queer and nonbinary communities (Davis 2019, Mallick, Thoma, and Shenassa 2022; Yam and Fixmer-Oraiz 2023). Today, a growing number of doula-certifying organizations exist around the world. Doulas are self-employed entrepreneurs, members of collectives, employed by hospitals or clinics, and serving wide geographical areas or their own local communities. While doulas have been practicing birth work in a variety of contexts for decades, until recently doulas have not gained much scholarly attention, therefore the size, scope, and demographic characteristics of the doula workforce are not well understood (Guenther, Kett, and Frogner 2022).

Since the emergence of DONA, and the proliferation of other certifying organizations, doulas have sought certification for various reasons: to gain knowledge through training, to secure legitimacy in the eyes of healthcare providers and clients, and more recently, to gain access to clinical spaces and reimbursement that are otherwise not available to them (Henley 2015; Norman and Rothman 2007, Davis-Floyd and Sargant 1997; Adams 2022). Given the range of options doulas now have for training and certification, many doulas are considering whether the core values and priorities of different training and certifying organizations align with or contradict their own values and lived experiences. Some of the oldest and most widely recognized doula certifying agencies trained doulas to view advocacy as outside their scope of practice, while many newer community-oriented organizations have pushed for an emphasis on cultural humility and equity, and view advocacy as integral to the care doulas provide. Given the increasing national recognition around reproductive injustices and racial inequalities in the United States, many doulas are seeking certification and training that works toward reproductive justice and racial equity.

A decade ago, doulas could choose to train and certify with any organization that met their needs. However, more recently, policies related to certification and insurance reimbursement followed by protocols instituted during the COVID-19 pandemic, created bureaucratic pressures and constraints for doulas. During COVID-19, doulas were excluded from clinical spaces as they were deemed non-essential workers (Adams 2022). Once permitted to return to hospitals and birth centers, they faced new demands to present certification credentials for reentry (Turner et al. 2022; Castañeda and Searcy 2020). While many hospitals have removed their certification requirements since the acute phase of the COVID-19 pandemic ended, recent efforts by states to introduce bills aimed at reducing maternal health disparities have linked the reimbursement of doula care to specific certification requirements (Ogunwole et al. 2022). As Ogunwole et al. (2022) argue, these efforts have not been focused on racial equity, and therefore create constraints and barriers for broad and equitable access to doula care.

One of our primary concerns with the increasing requirements for doula certification is that bureaucratic entanglements often run counter to efforts to provide high quality and equitable care (Fisher and Tronto 1990). Bureaucratization creates uncertainty and subjectivity, while having arbitrary and often negative effects on care. The current challenges faced by doulas in US hospitals underscores the ways that the obstetric institution impacts the care that birthing people receive, often enforcing a biomedical model of birth (Davis-Floyd 2022; Smith-Oka 2013, van der Waal et al 2023). Much of this literature has been focused on how structural forces, often intertwined with racism, hospital hierarchies, and an overworked labor force, inadvertently trickle down to impact the birthing person's intimate experience. The long history of doulas' efforts to gain legitimacy in clinical spaces and the simultaneous push-back by doctors and hospitals, lead us to believe that at least some of the exclusionary policies that have emerged and

that remain in place are intended to maintain control. As Davis articulates in her theory of uneven reproduction, "governing regimes make economic and ideological investments in *policies, practices*, or *programs* generating a calculus that requires placing one group at greater advantage in comparison to another group" (2023, 153). In the case of doulas, the policies that regulate certification are part of a larger calculus that restricts doulas' access to hospitals and reimbursement. As doulas report, this means that the very groups most at risk in obstetric spaces could be denied their chosen form of support, generating the uneven reproduction Davis describes.

While the stated purpose of bureaucratic rules and procedures is to increase efficiency, safety and oversight, Tuckett (2018) argues that they often impact people in ways that differ from their stated intent. We take up van der Waal et al.'s argument about the nature of the obstetric institution as we consider the bureaucratic policies imposed on certification for doulas. Doulas offer a counter-model of care to the obstetric institution, which promotes a pathologized biomedical care for pregnancy and birth and value authority, science, hierarchical power structures, and a clearly defined professional boundary around obstetrics (van der Waal et al 2023). For Van der Waal et al. the obstetric institution is "forged through histories of racialized appropriation." From an abolition framework they question the ideological underpinnings of obstetrics, asking "why is obstetric care the only form of maternity care that is accepted as safe despite evidence of safe alternative forms of care?" (2023, 110). Doulas are a safe alternative form of care for people giving birth in the United States, especially those who are at higher risk because of obstetric racism. The obstetric institution's attempt to regulate doulas came at a moment when the COVID-19 pandemic, police brutality and Black Lives Matter activism highlighted the deep racial inequities in the United States. As doulas diversified their options for

certification and training in response to a desire by birth workers and birthing families to access culturally appropriate, inclusive, and advocacy-oriented care, regulation of doulas and doula certifying organizations emerged in order to maintain power and control over birth spaces.

One way obstetric institutions attempt to regulate care is through the material culture of bureaucracies (Hull 2012). Documents, such as paperwork or in the case of our interlocutors, proof of doula certification, are key instruments of bureaucracy. As Matthew Hull notes, documents are not merely passive objects but are mediators. He states, "Documents are not simply instruments of bureaucratic organizations, but rather are constitutive of bureaucratic rules, ideologies, knowledge, practices, subjectivities, objects, outcomes, even the organizations themselves" (Hull 2012, 253). Papers do work - in some cases they can enable and facilitate (or deny) entry into caregiving spaces (Armin 2015). As we explore below, several of the doulas we spoke with mentioned the need to produce an identification badge, an arbitrary gatekeeping mechanism that impacts care. Training and certification requirements produce additional financial barriers for doulas, who are already poorly compensated (Ogunwole 2022). This is most likely to impact marginalized communities, who have neither the time nor money to pursue doula certification. As Akil Gupta reminds us, bureaucratic processes are not oriented towards equity. He states, "Bureaucracies are indifferent to the social suffering of the poor" (2012, 41).

In the interest of greater equity, public discourse and recent policy shifts have favored the inclusion of doulas and midwives in historically marginalized communities in order to improve the appalling maternal health statistics, particularly among Black and Indigenous women in the US. At the same time as doulas are being more widely recognized and compensated for their work, we have observed healthcare institutions and insurance providers respond by increasing bureaucratic barriers for doulas who are not certified with larger, more well-known, and less

activist-oriented organizations. Bureaucracies, like hospitals, wield power (Foucault 1977; Clegg 1998). As the potential for doula care has been brought to public attention, so have powerful hierarchies sought to gain some control over the types of doulas that are allowed to provide care. Yet, as our data demonstrate, doulas often jump through bureaucratic hoops and sensitively navigate hierarchical relationships in healthcare institutions to enable care. Doulas do not inherently trust these bureaucratic processes. Rather, they adapt to new bureaucratic constraints, such as certification requirements, in order to privilege the provision of care. Doulas navigate structural, bureaucratic, and interpersonal constraints to enact the best care possible within the circumstances.

Motivations for, and value of, certification

To fully understand our critique about increased surveillance and regulation around certification, it is important to understand how doulas themselves see the value of certification and their reasons for seeking it. Prior to COVID-19 regulations, doulas sought certification for a variety of reasons. For some people starting out as doulas, enrolling in a certification program was seen as an entry point, a way to gain knowledge and access to information networks that could help them begin their doula work. Doula training often connected doulas with a mentor so they could accompany an experienced doula to births and gain some practical experience. As Lucy, a doula from North Carolina, explained:

> When I first started researching becoming a doula, I understood that there was no regulation, that there was no training necessary, but it was out there. And I decided, 'Oh, I'm gonna get certified.' Because it seemed to have value for me, so that I could learn more and legitimize myself.

Like many seasoned doulas, Lucy chose her certifying organization from a short list of three or four options. Knowledge and informational support are at the heart of doula care, so many doulas are intrinsically motivated to seek opportunities for continuing education. Like Lucy, Grace was

interested in learning everything she could to help her as a doula in the Nashville, Tennessee community. She said:

> I started out the gate. I was wanting to get all the certifications. I wanted all the alphabet behind my name. I wanted to be great… I'm a perpetual learner. I just enrolled in a whole other training program…So I'm a strong advocate for learning and training.

While many doulas - particularly inexperienced ones - mentioned the knowledge gained from their training as being valuable to them in their work, the value of knowledge gained in certification training was not the most cited reason for becoming certified or maintaining an up-to-date certification.

Instead, many doulas told us that legitimacy was a major reason they chose to pursue certification and training. As Sophia, also from the Nashville area, noted, "I felt like having a piece of paper or letters after my name shows that I work very hard. That I took my work seriously. That was very important to me." Rachel, a doula from Texas, also felt that the legitimacy of certification was important, but her motivation was tied to the perceptions about certification within the logic of biomedicine. She explained:

> Because I worked in a hospital, certification was a must for me. Which is a very privileged standpoint and I recognize that…I know how much a certification means to the medical system. If that means I can support somebody better within the system, then I will do it.

Rachel's motivation for certification was to facilitate care for her clients by increasing her legitimacy from the perspective of the healthcare providers in the hospital.

Because there is no governing body that regulates what a doula training should include, there is no baseline or national standard for what a doula training should accomplish. This has given doula training organizations ample freedom to set their own standards and curricula. It has also meant that the content and rigor of each doula training is highly variable. Many doulas, for

example, specifically mentioned that they had originally trained with DONA, but were seeking to recertify with a more progressive organization that supported advocacy, inclusive language, and full spectrum care that also supported people having abortions. Veronica, working in North Carolina, said:

> I just let my certification expire with DONA and I am currently getting recertified with DTI. I found it's the most progressive as far as I can find…It's very important that I'm using language that everyone feels included in on, and I want to be there for people terminating their pregnancies.

Emily, from Connecticut, was harsher in her evaluation of DONA. She said:

> I see these young, radical doulas that are doing such interesting trainings. I've heard a couple of them really talking about the doula industrial complex so now I decided I'm not going to recertify with DONA. It never felt like it was too expensive. For me as a full-time doula it was just one of many business expenses. But at this point, I don't really feel very proud to be associated with the organization.

DONA has also been widely critiqued by doulas because they have historically been opposed to doulas acting as advocates in the birthing space. However, doulas who work with marginalized communities often see advocacy as central to their care, as they work to prevent obstetric violence and harm. In response to these critiques, and because of new leadership, DONA has begun rethinking some of their positions on such things as advocacy and inclusive language. These changes have the potential to bring DONA in line with many doulas' own goals and values as they seek certifying organizations. Ultimately, the proliferation of doula certifying organizations allow doulas to choose training that matches their values and meet the needs of the communities they serve.

Despite a lack of oversight, hospitals and healthcare providers have little to no understanding of what doula certifications mean, or an awareness of the difference between one certification and another. During the pandemic, when asked for her certification in hospitals, Rachel, introduced earlier, said "They have no idea what they're looking at. I firmly believe that.

They're looking at an expiration date. And making sure it's you." Doulas also noted that hospitals do not differentiate between certification and training. While a doula may be certified, they might not have any hands-on experience. Certification in no way indicated a doula's level of experience. As Lucy shared, "I had people applying for jobs with us [in North Carolina]. Saying I'm a certified doula. And in conversation, I learned that they have never attended a birth." Loren, from Texas, said, "I have mixed feelings. I mean, it's nice to be certified to say to some people who care about certification, but I guess it doesn't tell how experienced you are." Michelle, a doula in Oregon, was blunter in her assessment of certification, "It's really the experience that makes a great doula and knowing what you're good at and not trying to be everything to everybody…I don't think certification makes the doula."

In contrast to their experiences in hospitals, especially during COVID-19, many doulas said that while they have been asked by potential clients about their experience as a doula, the only time they are ever asked about certification is if it is required by someone's insurance in order to seek reimbursement. Phoebe said about her work as a doula in Iowa, "I don't remember a time when a potential client has ever asked me if I'm certified or cared honestly." Instead, Loren, introduced earlier, recommends that people seeking to hire a doula should interview them to see if they have a connection. She advises them, instead of asking about certification, "Find someone you can connect with, find someone you can trust..I think that's the most important." Doulas and their clients did not see certification as evidence of their experience or their expertise. Furthermore, their primary reason for seeking certification was not to improve care for their clients. Rather doulas sought certification to enter the profession, to expand their knowledge, and to gain legitimacy among peers or especially in a medical setting.

COVID-19 and the Gatekeeping of Care

When COVID-19 overwhelmed the United States in early 2020, doulas were faced with prohibitions that kept them from offering the kind of care that was the hallmark of their profession. As hospitals rolled out restrictive policies, many doulas were no longer able to offer continuous presence and embodied care for birthing families (Castañeda and Searcy 2020; Adams 2022). These new policies spanned from allowing only certified doulas, often with their own personal protective equipment (PPE) and on pre-approved hospital lists, to forcing pregnant people to choose only one support person, and in extreme cases, to banning any labor support– whether by a partner or doula (Yakovi Gan-Or 2020; Thayer 2020). Doulas explained how COVID-19 changed hospital policies and local or state regulations, which made it challenging for them to provide in-person care.

One of the biggest obstacles for doulas during the pandemic was responding to constantly shifting policies that impeded their ability to provide in-person continuous care for birthing families. Policies included requiring a negative COVID-19 test, proof of vaccination, or proof of certification from particular, and seemingly arbitrarily selected doula certifying organizations. Jill expressed frustration with the rapidly changing situation in Seattle: "The biggest change was just we weren't sure at any given moment if we were going to be able to join our labors with our folks. The rules were changing every day. Whether or not you had to be a certified doula was changing every day." Emma, also working in a major urban setting in New York, added, "In the height of it, it was literally changing from day to day and the doulas were connecting with each other through social media and saying 'I'm at Mount Sinai right now', and 'I can't get in' or 'I'm having to show proof of vaccine' or 'now I think you can test.'" The changing policies limiting doula access created obstacles for doulas trying to support families during childbirth.

At the start of the COVID-19 pandemic, when some hospitals were only allowing one support person in the room, some doulas were chosen over a spouse or family member, a wrenching decision for families and doulas. Recounting the birth story from the family's perspective, Anne, working in a small midwestern city in Indiana, described the fear one family expressed about being abandoned by their doula in a critical moment:

> So then when in March 2020, like literally at you know, 11 o'clock at night or whatever it changed…Now, you can only be here if you're certified…so from the family's perspective it was like, 'Yeah, my doula got pulled into the hallway and was asked to show her certification card or else she would have to leave.'

These examples reveal the confusion and whiplash that doulas experienced as they tried to navigate rapidly changing policies impacting their ability to provide care to birthing families. The global COVID-19 pandemic revealed where doulas fit in the hierarchy of hospital births, and it highlighted their liminal position and limited power within clinical spaces (Cheyney et al. 2014; Simonds, Rothman, and Norman 2007). In addition, shifting hospital policies affected how doulas provided care and further foregrounded the emerging role of certification.

Doulas pointed to a variety of policies enacted by hospitals amid the COVID-19 outbreak that they regarded as creating restrictive barriers to care (Searcy and Castañeda 2021). Hospitals required doula certification, state certification, contracts that mandated certain kinds of compliance and behaviors from doulas, background checks and badges. Michelle pointed out that some hospitals in her area of Oregon selected certain doula certifying organizations and designated those as permissible. They did this despite a lack of knowledge about doula care and training. She said, "It was more hospital by hospital, saying only doulas that have DONA, Kappa, Childbirth International and Pro Doula were allowed in. And those are four very big organizations. And so that wiped out a lot of [doulas] that chose different training organizations." Michelle indicates the way hospitals tended to allow certifications from larger certifying

agencies which had the effect of "wiping out" the doulas who trained with smaller or more local organizations. She also pointed out that some hospital policies bypassed doula certifying organizations altogether and enforced state doula certification instead. She said, "Our hospitals specifically [said] you need the state certification. So that wiped all of us out because it was like none of us had that. It's a four-month long process. So what do we do with our clients that are due next week?" State certification was a complex, confusing and difficult process and by allowing only doulas who had completed this training to enter, hospitals cut off doulas from offering in-person care.

Doulas from across the US reported their frustration at the certification requirements. Nancy, working across several states in the midwest including Indiana, said "It's like blind gatekeeping. They don't actually know what they're looking for." Nancy, like many doulas, felt that hospitals typically had no understanding of what doula training entailed, what doula care involved or which certifying organizations might be "legitimate." Like Rachel, quoted above, Nancy recognizes that hospitals have no expertise about doula care. She went on to say hospitals were attempting to impose a kind of "hyper medical license" on the more "traditionally community based, non-medical approach" to care that doulas undertake. "It's hard to regulate," she said, "it's a wide-ranging skill set." Doulas saw new hospital regulations as deeply problematic because hospitals did not understand the kind of care doulas enact. Doulas see their care as deeply personal and intimate, tailored to a particular person at a particular moment in time as they consider all the different variables at play as a birth unfolds (Castañeda and Searcy 2015). In both the imposed regulations and in the doula's analysis of this moment, certification became a way for hospitals to attempt to define and regulate a doula's scope of practice without ever understanding what that scope of practice entailed.

Many doulas noted that, especially during the pandemic when certification was required, doulas who had attended hundreds of births might be kept out of the hospital, while a brand-new doula who had never attended a birth could be admitted based on a piece of paper. Monica, working in Texas, explained this when she identified the difference between certification and the embodied experience of learning to be a doula.

> Honestly most of the doulas I've talked with, we don't feel like our training really happened with the certification process, which is another reason we were all frustrated. But that was what was required of us to get in. Not how many births we attended, not what kind…I mean I could have been a doula for ten years and every client had their baby ten minutes after I got there. What does that mean? Nothing, and then I could have been a doula for one year and every single one of my births took 72 hours.

For Monica and other doulas, the hospital bureaucratic restrictions were meaningless because they couldn't account for the kind of expertise and experience doulas brought to their care work. A piece of paper, no matter from what organization, did not legitimize the care; doulas' experience, their relationship to their clients, and their attentive presence did. Hospitals' insistence on regulating doula certification to a standard form was in fact meaningless. In her experience from Connecticut, Emily believes "certification is just, it's like, if you're good at jumping through hoops."

Hierarchies inherent in healthcare settings hide, undermine, and attempt to regulate the relational nature of care work. As doulas discussed certification and its meaning for the care they provide, many criticized the hospitals. Bridget had forceful critiques about the way this gatekeeping impacted marginalized communities. She said,

> I feel very actively anti-certification for the purpose of gatekeeping folks both into the field and into spaces. And we know historically this work is done in communities…We didn't make this work up. And just because certification exists, doesn't make it legitimate, and especially communities of color have been doing this kind of care forever, literally. And the fact that a white woman decided to make a business out of it a couple decades ago doesn't make it legit. The fact that that is what hospitals are validating is really disgusting.

Bridget had been a certified doula on the East Coast who had worked in large urban hospitals for some time. When COVID-19 hit and hospitals implemented policies around certification for doulas, Bridget refused to enter hospitals anymore, citing her refusal within the context of a more complex criticism of certification. She points out that what constitutes legitimate certification *within* the doula community is itself problematic as many communities have been doing this reproductive care work long before doula certification came into existence. For her, the fact that hospitals validated certain doula certifying organizations was part of the larger inability of hospitals to see the care doulas, certified or otherwise, brought to their communities. Bridget is critiquing what counts as legitimate here - whiteness, business savvy, economic capital, and the means to jump through bureaucratic hoops.

Bridget was not the only doula who critiqued certification itself as gatekeeping and a barrier to care. A doula from Pittsburgh, Ashley said, "I think certification bluntly is a gatekeeping mechanism that allows doulas of privilege through and keeps out nontraditional folks, let's say. And by that, I mean, I work with immigrant doulas, rural doulas, doulas of color who could never go through certification." Ashley continued by pointing out how prohibitive the certification requirements could be with economic and time constraints, including extensive reading lists and essay assignments. She was working with Medicaid patients in a southern state that wanted to reimburse only certified doulas. She described the way bureaucracy inhibits care when she said:

> We're trying to explain to them that your patients who need it the most are going to be served by doulas who can't get certified because of financial barriers, language barriers, technology barriers, but they are still the most culturally relevant, culturally sensitive doulas that that patient needs. It's someone from their community who speaks their language who understands their cultural norms. But we as a white, hetero, patriarchal society are trying to regulate doula care that will regulate everything else. And it becomes

> a gatekeeping mechanism, unfortunately, that keeps out the doulas we need most in the work.

Ashley, like Bridget, sees certification as a barrier for communities and birthing people who could benefit from the care a doula could provide. As hospitals and state reimbursement systems interfaced with doulas in their attempts at standardizing and regulating care, they set up policies and procedures that effectively limited the kind of care that could be offered.

These various forms of gatekeeping by hospitals and policymakers mask ignorance on the part of decision makers about the nature of doula certification and training and the differences between various certifying agencies. Such gatekeeping also inhibits care because it fails to recognize how smaller or more local organizations could offer specific training and information on the hospitals and healthcare providers doulas would be working with. Finally, it keeps out doulas who may not have the means to maintain costly, time consuming, and often overly academic trainings, but who could provide the best support to families from marginalized communities who experience highest rates of maternal mortality and morbidity. Such gatekeeping mechanisms fail to acknowledge the way excellent doula care requires cultural competency, community awareness, and community trust, which is most often found in local smaller training and certifying organizations that cater to their given geographical locations and communities.

Much like how medical interventions can spiral into further complications for birthing people, administrative interventions directed at doulas created cascading bureaucratic impacts—ultimately compelling some doulas, like Ashley, to altogether refuse certification as a means of reclaiming radical autonomy. In doing so, Ashley engages in a bureaucratic refusal as a source of power. As Nash argues, “For some doulas it is this refusal to be counted that constitutes the kind of fugitive birth labor that doulas perform, that makes the profession powerful, transgressive and

ultimately radical" (2021, 85). Ashley explained, "I thought about going back and getting certified, but in the end, I feel more free as a doula to do the kind of justice and radical doula work I do without a certifying body. I feel like I can be more of a renegade doula if I'm not certified." In this quote it is clear, Ashely chooses the liminal space, deliberately rejecting the kind of legitimizing pressure bureaucracy wants to impose. Ashley wants her doula care to align with the kind of radical justice she works towards. She rejects certification so she can provide the kind of care she believes those she works with deserve.

CONCLUSION

Our work here is part of the project of "critiquing obstetric violence effectively" because we demonstrate one small way in which bureaucracy functions to uphold the larger institutional system of hierarchical relationships designed to keep some people in and other people out (Van der Waal et al 2023). In this case doulas provide a window into the negative impact of bureaucratization on care, and the ways that the regulation of doula certification enacts what Davis terms uneven reproduction, where policies and procedures promote the reproductive advantages of some groups over others. We argue that state and hospital investments in regulating doula certification cannot be separated from ideologies and power structures that shape the obstetric institution more broadly and are in line with other attempts to maintain control over how doulas can provide care. Given the racialized obstetric history of the United States, this is not a surprising move, and our research demonstrates the way regulating certification of doula care is part of a larger cultural project that insists on the obstetric institution as the only safe and possible form of maternity care (Van der Waal et al 2023).

Doulas occupy a liminal space in reproductive care, moving between home and hospital, as they support birthing families. Their capacity for care rests on an embodied, responsive

relationship they build with the birthing person. In contrast, gatekeeping by hospitals demonstrates how often care is constructed in biomedical terms "that authorize certain actors as care providers and certain activities as care" (Solimeo et al. 2017, 99; Buch 2015). The COVID-19 pandemic both enabled and demarcated a shift in how doulas were monitored and bureaucratized. During the pandemic, doulas were kept out of clinical spaces and were required to show certain types of certifications in order to do their work. These regulatory moves represent an overreach on the part of the obstetric institution that seeks to enforce hierarchy, science and authority over the relational models of care doulas provide.

Hospital policies, including those enacted during COVID-19, attempted to regulate both *who* could be considered care providers and *what* that care might look like. Their hyper focus on licensure and certification within the doula community, without actually knowing anything about it, revealed how biomedicine confers legitimacy on clinical licensing over the actual enactment of care. Doulas see their particular form of care as highly personal and tailored to the person in front of them. This means that legitimate care has a "capacity to evade standardization" in its "low-tech" and "high-touch" approach (Nash 2021, 84). Doulas define their work as outside of the clinical, emphasizing the continuous emotional, educational, and physical support they provide. They see their care as filling in the gaps that a biomedical approach to birth creates and their work is necessary to offer birthing people a more holistic experience than the typical technocratic experience of a hospital (Davis-Floyd and Cheyney 2019).

Doulas offer us insight into the shifting landscapes of care impacting birthing families and our maternal healthcare system. Yet the precarious position of doulas during the pandemic, and the ongoing regulation of doula certification beyond COVID-19, demonstrates the absence of an ethics of care within current institutions. As Van der Waal and Van Nistelrooji explain

there is a "structural tendency to separate reproductive subjects from their caring relations and reproductive capacity" a move that emphasizes reproductive bodies as "vessels" instead of seeing birth as process entwined within relationship of care (2022, 1190-1191). The pandemic amplified this structural tendency, effectively isolating people giving birth and cutting them off from relational care (Thayer 2020).

Examining how doulas navigate and reshape the contours of care necessitates a focus on hospital practices, including certification, and their consequences for birthing families. Doulas actively resisted gatekeeping and pushed to uphold their model of care. During the pandemic, doulas found ways to use their liminal status to creatively respond to new restrictions, even as it impeded their ability to provide continuous care. Yet, devaluing the relational care and emotional labor supplied by doulas placed birthing families at risk before, during, and after the pandemic. The liminal role of doulas was magnified during COVID-19, yet doulas have remained adaptable, leveraging this in-between status to resist constraints, barriers and gatekeeping while upholding relational care as the center of their practice.

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