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Partnering With Doulas in Clinical Settings

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This document is endorsed by DONA International, Doula Trainings International, the National Black Doulas Association, and the National Health Law Program.

Fostering positive and strong partnerships between clinicians and doulas is essential and can benefit patients, clinicians, and the workplace. The evidence suggests that, when doulas are part of health care teams, they improve patients' experiences and outcomes. Doula–clinician partnerships have demonstrated improvements in communication and patient-centered care, accountability in the health care team, and continuity of care for individuals who have given birth. Doula support aligns with evidence-based outcomes and reduces costs to the overall health system. Barriers to doula–clinician partnerships may be addressed with training and policy, as well as approaches that promote collaboration, communication, and accountability. There are opportunities for co-learning and collaboration to embrace the benefits of doulas' roles and to facilitate working together in the most optimal way to improve perinatal outcomes. Obstetricians are uniquely positioned to champion this partnership. This Committee Statement provides recommendations to foster symbiotic collaboration among hospital systems, clinicians, and doulas and to increase knowledge regarding a doula's role and scope of practice.

SUMMARY OF RECOMMENDATIONS AND CONCLUSIONS

Based on the principles outlined in this Committee Statement, the American College of Obstetricians & Gynecologists (ACOG) makes the following recommendations:

- **Obstetrician–gynecologists should educate themselves about doulas' spectrum of practice and the benefits of their work.**
- **Obstetrician–gynecologists should create synergistic, respectful teams that include**

doulas in ways that benefit patients and the workplace.

- **Obstetrician–gynecologists should educate patients about the various roles of a doula and should be aware of local resources to assist patients in identifying doulas and related community resources.**
- **Obstetrician–gynecologists should be aware that there are various coverage and access options for doula support.**
- **Obstetrician–gynecologists should advocate for and support research on partnerships with doulas and the roles of doulas in obstetric and gynecologic care.**

BACKGROUND

The term doula has its root in the Greek word meaning "servant," demonstrating service toward the pregnant or postpartum person. Although historically women were supported in their birth experiences by other women in their communities who provided deeply personal and continuous emotional reassurance, physical comfort, and practical help, this support was nonmedical. In modern health care systems, that continuous support sometimes has been lacking as clinical staff became more focused on medical procedures and family members did not have the experience and capacity to provide full support. In modern years, the term doula has been reclaimed to define a trained support person who offers emotional, physical, and educational support. Other providers of this care may include Indigenous birth workers and others who may not identify themselves as doulas.

Doulas come to health care spaces through different pathways and contracts. There also are various ways in which a health system can become affiliated with doula services, including building relationships with community doulas, supporting and investing in doula training, or enlisting community volunteer support persons (1). Studies have shown that doula support from family members

Table 1. Types of Doulas and Examples of Care Provided

Type of Doula	Support Offered
Birth	Supports parents during pregnancy to prepare for labor and delivery with education, resources, and guidance; provides comfort and emotional support during labor and delivery, and the immediate postpartum period; provides postpartum education and debrief after birth
Postpartum	Offers support to individuals and their newborns after delivery, such as newborn care, breastfeeding, emotional well-being, and urgent maternal warning signs; helps the family prioritize rest and often performs practical tasks, including light housekeeping, organization, and meal planning
Full-spectrum	Offers support throughout the prepregnancy, pregnancy, delivery, and postpartum periods; may also include abortion, early pregnancy loss, and stillbirth
Fertility and prepregnancy	Provides educational and emotional support to address the stress and emotional effects of infertility during the prepregnancy stage; debriefs with client after reproductive endocrinology and infertility procedures and appointments
Family transition (birth of sibling and adoption)	Provides age-appropriate education on sibling integration and support for siblings during birth of new child; support may include transition from biological mother to adoptive family
Abortion	Provides emotional support before, during, and after procedural or medication abortion; may transition into bereavement support
Bereavement and perinatal loss	Provides support for abortion, early pregnancy loss, and stillbirth
Death and end-of-life	Provides emotional, spiritual, and practical support to individuals and families navigating grief and the dying process
Menstruation and adolescent health, menopause and perimenopause	Provides education about the reproductive lifecycle, anatomy, and period products; sexuality education (eg, contraception use, sexually transmitted infections); education about and support for menopausal symptoms

who have been trained (2) and virtual doula support provided through digital platforms also are effective strategies (3). The scope of doula work remains the same regardless of pathways to health care settings. There are many different types of doulas who offer full-spectrum support or support at various stages of life—including, but not limited to, menstrual health, fertility, abortion, pregnancy and birth, postpartum, perinatal loss and bereavement (Table 1)—but much of the available data on benefits focus on birth doula support. The benefits of doulas and the recommendations in this document apply to various types of doulas.

There are multiple pathways to the field, including various certification bodies and apprenticeships. Many doulas have extensive experience through apprenticeship. Doulas with decades of experience may never be certified for many reasons, including structural barriers (eg, financial and linguistic hurdles), a resistance to the medicalization of birth, and a commitment to a long history of traditional and Indigenous training that is passed down generationally (4–7). A lack of formal training or certification does not mean that someone is not qualified to provide traditional doula support. Birth doula training typically includes completion of curricula around philosophy of care and support and may include the topics listed in Box 1. Culturally responsive doula training that advances birth equity also includes respectful care; implicit bias; reproductive justice; trauma-informed support; health equity; and the lived experiences of Black, Indigenous, and other marginalized birthing families. A formalized birth doula training format may include classroom instruction, online learning, and hybrid courses ranging from 24 to 40 hours. Certification usually includes attending births, 6–12 months of additional research, essays, continuing education, mentorship, business development, and marketing. Postpartum training includes additional learning topics. Organizations such as HealthConnect One have developed recommendations for core competencies to strengthen and standardize doula care (8).

Box 1. Training Topics for Birth Doulas

Birth doula training typically includes the following topics (*note: the below list is not exclusive*):

- Signs and symptoms of labor
- Medical terminology
- Stages of labor
- Immediate postpartum care
- Lactation
- Advocacy
- Surgical and vaginal birth preparation (including asking about a birth plan)
- Aspects of induction, fetal positioning, and cesarean birth
- Approach to the Birthing Bill of Rights*
- Interaction and collaboration with hospital staff, clinicians, and nurses
- Pain management, comfort measures, and nonepidural pain-management alternatives
- Evidence-based birth interventions
- Labor-support tools
- Holistic and mindfulness practices
- Essentials for birth support (including positioning for progression of labor) and relationship-building with partners or support persons or both
- Scope of work
- Ethics and responsibility
- Privacy and protected health information

* For more information, see National Association to Advance Black Birth. Black birthing bill of rights. Accessed March 25, 2026. https://www.thenaabb.org/black-birthing-bill-of-rights; Birth Justice Collaborative. My birthing rights: a resource guide for Minnesota birthing people. Accessed March 25, 2026. https://www.birthjusticecollaborative.com/birthing-bill-of-rights; *and* California Black Women's Health Project. Birthing people's bill of rights: COVID-19 edition. Accessed March 25, 2026. https://www.cabwhp.org/uploads/5/6/6/4/56647115/birth_justice_covid19_bill_of_rights_final_1.pdf.

The role of doulas in the perinatal care of birthing parents and newborns is complementary to the medical team. Doulas primarily support self-advocacy or advocate for their clients, provide physical and emotional support, help their clients navigate medical decisions and communicate their preferences, educate them on the labor and birth process, and address health-related social needs and social drivers of health (9). Doulas also provide patient education and resources, including childbirth education and general anatomy and physiology to enhance awareness of changes during pregnancy and stages of labor. They support health behaviors such as optimal nutrition, exercise, and sleep hygiene; provide referrals and resources concerning preventive health; and may build out the care team by developing proactive partnerships to include traditional medicine and providers of holistic care (eg, mental health therapists, counselors, pelvic floor physical therapist, lactation consultants). They help navigate and provide referrals to address social drivers such as transportation, food, and housing insecurity (9, 10).

Advocacy is a key piece of the role of doulas. They amplify the voice of the patient during interactions with clinicians, including assisting the client to develop questions and scripting around medical interventions to elicit more in-depth understanding before decision making. A cross-sectional survey of 2,138 women found that 17% reported experiencing mistreatment during their maternity care, including loss of autonomy; being shouted at, scolded, or threatened; and being ignored, refused, or receiving no response to requests for help. The rate was even higher for Black, Hispanic, and Indigenous respondents (11). An essential aspect of the client–doula relationship is creating an emotionally safe and vulnerable space for the client to express concerns and preferences and to assist in amplifying the client's voice if needed or desired. The type of advocacy provided by a doula is individualized according to the client's personality, needs, and specific situation. Although interprofessional training is part of medical training (12, 13), medical education for clinicians rarely has included collaboration with doulas. Due to a clinician's potential lack of familiarity with the role of a doula as a patient advocate and promoter of a patient's self-advocacy, there may be tension between the clinical team and the doula. When the doula communicates on behalf of the patient, it may affect a clinician's perception of the ability to communicate with the patient and to develop a therapeutic relationship. This aspect of the doula role may exacerbate power dynamics of the doula–clinician relationship; however, there are opportunities for co-learning and collaboration to understand this dynamic and relational autonomy, to embrace the benefits of doulas' roles, and to

Box 2. Strategies to Foster Open and Positive Communication

- Empower patients to consider what they may want in a doula (eg, what types of support) and what questions they may consider asking about the doula (eg, training, work experience, availability, services package, means of communication, fees and payment methods, and places of meeting).
- Include questions during prenatal visits (to introduce doula relationship as early as feasible and establish open lines of communication):
  - *Are you working with a doula?*
  - *Are you collaborating with a doula on birth preferences? If so, can you share your preferences (eg, mobility, pain management, cord clamping) with me?*
- Welcome doulas to patient appointments.
- Plan or participate or both in meet-and-greet events with community doulas.
- Support avenues for doulas to share feedback or concerns (eg, phone number).
- In situations in which doulas may be communicating on behalf of a patient:
  - Acknowledge doula, thank them, and ask for verification from the patient.
  - Ask clarifying questions to the patient to center them in the therapeutic relationship.
  - Encourage direct communication with the patient; assess why the patient may not be communicating.
  - Consider inviting another clinical team member or colleague to join the conversation if the clinician deems that another perspective may be helpful.
- Be aware of state and local laws and institutional guidelines about what spaces doulas can be in (eg, operating rooms, triage, postanesthesia care unit) and support the inclusion of doulas in all applicable spaces.
- If communication between the clinician and doula becomes adversarial during a medical emergency that could have negatively affected patient outcomes, encourage a postbirth debrief, including the doula, to identify issues and opportunities for co-learning and potential improvements.

facilitate working together in the most optimal way to improve perinatal outcomes (see Box 2).

The certification process for doulas is highly varied, including number of hours trained and criteria for state certification, and there is no single certifying body for doulas. As an organization representing physicians, ACOG does not endorse a specific certification pathway for doulas. State Medicaid agencies adding doula benefits to their programs require varying core competencies (eg, training in lactation, stages of labor, and other topics) for doulas to become Medicaid providers. Because there is not one certifying body, there is no one universal system to report grievances and ensure accountability and its equitable application. Grievances can be addressed using local hospital mechanisms, pathways, or protocols and by the certifying body, if available. It is critical that the processes for grievances and accountability are not unidirectional (from obstetrician–gynecologists to doulas). The American College of Obstetricians & Gynecologists encourages institutions to create avenues for doulas to present grievances as well (eg, communication with the labor and delivery department leadership, letters to departments).

Doulas' holistic approach complements clinicians' biomedical view of the perinatal period (14). With worsening maternal health outcomes and increasing pressure on maternal health systems, collaborative care models are needed. Doula–clinician partnerships have demonstrated improvements in communication and patient-centered care, accountability in the health care team, and continuity of care for individuals who have given birth (14–16). Strong evidence demonstrates shorter length of labor, fewer cesarean deliveries, higher birth satisfaction, and higher rates of breastfeeding initiation with continuous support for the patient during birth (17–20). Based on these benefits, as of 2025, almost half of U.S. states cover doula services through Medicaid; updated lists of states are available from the National Academy for State Health Policy (21) and the National Health Law Program (22). Now is the time to strengthen partnerships between clinicians and doulas (eg, autonomy, relationship, and closeness with patients). Obstetricians are uniquely positioned to champion this partnership. As the national conversation on maternal health and doula support accelerates, this Committee Statement provides recommendations to foster symbiotic collaboration among hospital systems, clinicians, and doulas and to increase knowledge regarding a doula's role and scope of practice.

RECOMMENDATIONS AND CONCLUSIONS

Obstetrician–gynecologists should educate themselves about doulas' spectrum of practice and the benefits of their work.

Maternal morbidity and mortality have increased steadily for the past three decades (23). Considerable racial and socioeconomic inequities exist in maternal health outcomes in the United States (24, 25), and disparities persist across educational and age strata (26). Despite concerted efforts, effective interventions to reduce inequities in maternal health outcomes remain elusive. The doula–clinician partnership is emerging as an evidence-based and cost-effective model to address social drivers of perinatal health, inequities, and complications (27). Doulas provide continuous support during pregnancy, labor, and birth and facilitate communication between clinicians and patients and their support persons. This promotes a shared decision-making process in which the patient feels empowered, leading to the formulation of an effective, agreed-upon strategy for risk minimization and management of complications. Doulas provide practical support during the labor process, including encouraging the parturient to move and providing counterpressure and physical comfort measures. Emotional support that includes reassurance also is part of the doula role (28). Furthermore, the doula assists the patient and the primary support person to navigate the health care–delivery system more efficiently by mitigating institutional obstacles that hamper access to care (eg, complex, intimidating, or discriminatory institutionalized formalities and protocols). This navigation helps create familiarity with institutional practices and procedures, supports better rapport, and encourages enhanced adherence to prescribed prevention measures. This leads to improved access to quality care, risk minimization, and optimized management of pregnancy.

The support doulas provide, especially to marginalized pregnant individuals, may be instrumental to improving maternal wellness and perinatal outcomes. Doula support during labor is associated with fewer cesarean deliveries, fewer birth complications, higher breastfeeding rates, and higher rates of satisfaction with the birth experience (17–19). Furthermore, doula support has been associated with fewer maternal complications among socially at-risk women facing higher rates of maternal morbidity and severe maternal morbidity (17–19, 28–31).

Data suggest that doulas, especially those providing support to individuals in marginalized communities, can improve communication between pregnant women with low income and their clinicians (32). Black women who received doula support reported enhanced communication and information sharing as well as improved emotional support (33, 34). Community-based, doula-led interventions have demonstrated improved maternal knowledge of medication and substance use during lactation among Black and Hispanic women with low income (35), as well as improved infant feeding intention and breastfeeding knowledge among a racially and ethnically diverse group of pregnant women (36). Language concordance between the client and doula may be useful in navigating perinatal care (37, 38); however, doulas do not replace the need for medical interpreters.

Data also demonstrate benefits for other at-risk populations. A study using DONA International birth doula data (n=1,968 births) found that adolescents (aged 15–19 years) who experienced doula support had lower rates of cesarean delivery and premature birth when compared with national statistics for this age group (29). Incarcerated individuals who had doula support during birth reported feeling less alone, better informed, and more able to cope (39, 40). A systematic review of the literature on the needs of incarcerated women includes educational and supportive care (41). Trauma-informed doula care may be especially suited to those who are incarcerated or have substance use disorders or both (42). A qualitative study of an opioid-treatment program found that doulas helped pregnant people with substance use disorders navigate a health care system that often is stigmatizing and judgmental. Participants also reported that doulas' emotional support was useful for recovery from addiction (43).

Obstetrician–gynecologists should create synergistic, respectful teams that include doulas in ways that benefit patients and the workplace.

Synergy between clinicians and doulas improves patient outcomes, primarily by providing complementary care that may not be addressed by other members of the care team. When discussing their roles, doulas highlight that the relationship they build with their clients includes a form of supportive prompting in which appointment reminders, healthy habits, and positive affirmations are provided consistently (9). This surveillance allows doulas to effectively monitor pregnant individuals for social needs that other health care team members may be unable to address due to time constraints. By checking in with clients, doulas reported being able to notice "red flags" or warning signs more easily (9) and the importance of their role in providing necessary, and sometimes lacking, education on essential topics, including perinatal mental health (44).

During the prenatal period, including early labor, doulas may meet with clients to prepare them for labor, birth, and the postpartum period; educate them about available resources; and support them emotionally and mentally. In the intrapartum period, doulas' continuous presence and assistance with positioning to assist with labor progression may help staff. During the postpartum period, doulas facilitate confidence and skill-building in feeding and newborn care while also aiding parents in maneuvering through physical changes, whether after a surgical or vaginal birth. The work of doulas covers a wide spectrum, but it is individualized based on preference or access for specific clients. A doula's trusted position in the family allows for keen observation and open conversations about mental well-being, not only for the client but also for partners. Being part of a supportive social network can foster a sense of belonging and may increase motivation for self-care (45). Doulas engage and educate members of the client's support network to help them meet their needs.

Fostering positive and strong partnerships between clinicians and doulas is essential and can benefit patients, clinicians, and the workplace. Obstetricians are needed to champion these efforts, and the doula–clinician partnership and collaboration should extend to the full clinical team. The benefits of doula partnerships have been reported beyond perinatal settings, including collaboration with abortion and end-of-life, or death, doulas (46, 47). For example, a randomized controlled trial found that both patients and medical assistants reported favorably on the presence of abortion doulas; the medical assistants felt the doula's emotional support of the patient allowed them to better focus on supporting the clinician (46). These team relationships must be built on trust, mutual respect, and a shared commitment to improving outcomes for every person. Doulas should be seen as an integral part of the care team and should not be excluded automatically during escalating medical situations, if possible. They also should not be excluded during times of crisis (eg, pandemics or natural disasters). See Box 2, Strategies to Foster Open and Positive Communication, for examples of how to foster collaboration.

Obstetrician–gynecologists should educate patients about the various roles of a doula and should be aware of local resources to assist patients in identifying doulas and related community resources.

Though the role of doulas in health care settings has increased substantially in the past few decades, the literature demonstrates that many—both health care workers and the general public—still do not recognize the benefits of doulas. As reported in a 2024 study, doula services are underutilized by pregnant and postpartum people of color due to a lack of knowledge of doulas' roles and the benefits of their work (48). An evaluation of a multicultural, multiethnic Massachusetts community's understanding of doulas revealed that most were unaware of the availability of services, were confused about what services a doula could provide, or thought that doulas were needed only for home births or that doulas were appropriate for pregnant individuals who were not like them (49). In response to the Surgeon's General 2020 call to action to reduce maternal mortality (50), insurers and communities have invested in community care providers, including doula support. Due to this recent large investment, doula care has become affordable for more pregnant people who currently may not be aware of the support and resources provided by doulas (51). To address this lack of awareness, obstetrician–gynecologists should provide education and resources to connect patients with doulas in their communities (Box 3). Clinicians can encourage patients to think about what

Box 3. Strategies for Doula–Clinician Partnerships

- Provide identification badges (to treat doulas as members of the team and not visitors).
- Encourage doula familiarity with the physical space of the hospital or birthing center through tours.
- Create clear and respectful pathways for doulas, nurses, and clinicians to report or share when things go well and go wrong:
  - Anonymous reporting
  - Shared issue-resolution processes
- Maintain a list of trusted and representative doulas or doula directories (eg, DONA International, National Black Doulas Association, DoulaMatch.net, CAPPA, National Health Law Program, and state-level resources) to share with patients if requested.
- Ask every patient about knowledge of and desire for doula support.
- Share educational resources regarding doula support for patients, including scope and benefits, eg:
  - Using a Doula for Pain Relief, 2018 (Evidence Based Birth)
  - Evidence Based Birth Podcast: Doula, 2018 (Evidence Based Birth)
  - Hiring a Doula: A Guide for Parents, 2022 (DONA International)
  - Position Paper: The Birth Doula's Role in Perinatal Care, 2022 (DONA International)
- Develop and disseminate educational resources for clinicians on doulas' training, scope of work, and payment options; identify neutral sources rather than resources from one group or organization.
- Create educational resources for doulas regarding different clinical spaces.
- Support policies or guidance that reduce paperwork and other institutional burdens that may limit access to doula care.
- Opportunities for relationship-building and to enhance communication:
  - Team steps
  - Bedside huddles
  - Postcare debriefs
  - Recurring community meet and greets
  - Simulations
  - Joint meetings and workshops (eg, grand rounds)
  - Hospital–doula liaisons

types of emotional and educational support they desire and what they may want in a doula partnership.

Obstetrician–gynecologists should be aware that there are various coverage and access options for doula support.

Payment models for doula services vary and may include a flat-rate service charge, fee-for-service models, monthly stipend models, grants that pay doulas, and set salary structure models that incorporate doulas as staff (16). A retrospective analysis of a nationally representative survey found that, when compared with women with private insurance, those with public insurance were almost twice as likely to want but not have doula care (52). Additionally, the cost of doula services was a potential barrier preventing Black families or those with low income or both with public insurance from receiving the services they desired (52). Although Medicaid coverage for birth doulas has expanded to many U.S. states, each state that has implemented coverage has varying rates and processes for reimbursement.

It is important to note that, despite increasing Medicaid coverage, implementation historically has been and remains challenging, with a minority of doulas ever receiving third-party reimbursement and the vast majority reporting needing other paid jobs to financially supplement their doula work (53, 54). Barriers to reimbursement remain a challenge, as evidenced by a 2024 qualitative study of 31 Florida-based doulas who served clients with low income. Doulas identified the Medicaid reimbursement process as a critical barrier to doula participation in the program (55). They chose not to participate due to hurdles in obtaining reimbursement and low reimbursement rates. Arduous Medicaid processes and limited doula education on how to navigate the process may

limit the engagement of doulas with Medicaid and, thus, limit access for people with Medicaid insurance. It is important to note that, although ACOG does not comment on payment for doulas or any nonmedical or medical professionals, doula payment should not be a part of the direct payment from insurers to obstetrician–gynecologists.

Doula coverage by private health insurance plans is less common (56). As of 2025, only a few states required coverage of doula care with private health plans and others were in the process of implementing doula coverage in private health plans (57). More states are expected to continue efforts to require doula coverage for private health plans. Health Savings Account and Flexible Spending Account benefits may be used by some patients to cover doula support.

Community-based organizations, nonprofits, and health departments provide free or low-cost doula care through grants or donations. These programs typically prioritize marginalized families. Moreover, some hospitals or birth centers employ doulas or work with them as part of the maternal care team at no additional cost to patients. Notably, hospital-based doulas, in contrast to community doulas, have obligations to their employer as well as the patient.

Obstetrician–gynecologists should advocate for and support research on partnerships with doulas and the roles of doulas in obstetric and gynecologic care.

More data are needed on the benefits of other types of doulas beyond those in the perinatal space (Box 1), including reimbursement models that help sustain the doula workforce. Much of the research has focused on hospital-based or program-based doula support, and more data are needed on independent doulas and doula support in nonhospital settings, such as birth centers. Research on doulas has focused primarily on outcomes associated with pregnancy and birth; evidence on the effectiveness of doula care in the postpartum period is scant. Postpartum doula support with proper training may enhance the physical and mental well-being of families during the sensitive postpartum period or during times of extreme emotional upheaval (58, 59). A 2022 retrospective cohort study using Medicaid claims from California, Florida, and a northeastern state to compare maternal health outcomes between 298 pairs of women who did and did not receive doula care demonstrated 58% lower odds of postpartum depression or anxiety in those who received doula care (60). Use of doula services was deemed an effective strategy for improving maternal mental health among women with low income. Notably, the authors could not delineate whether postpartum visits by doulas also influenced the reduction in odds of postpartum depression or anxiety, highlighting a gap in the literature regarding the relationship between doula support in the postpartum period and postpartum health outcomes (60). Studies addressing postpartum support could focus on mother–child interaction, postpartum depression, self-esteem, and parenting, among other topics (17).

Though the role of doulas in health care settings has increased substantially in the past few decades, the current literature demonstrates a continued lack of awareness of the benefits of doulas among both health care workers and individuals who could use doula services. Research on implementation of doula services within health systems would allow for better interpretation of data and sharing of best practices across contexts (28). Additionally, research is needed to address the support of at-risk populations, such as rural residents, migrants, refugees, individuals with disabilities, and patients who are incarcerated (61, 62). Women are the fastest growing population in the carceral system, and 10% of those individuals are pregnant at the time of incarceration. They often are left to give birth alone (39). Doula support in these cases would allow for improved maternal and neonatal outcomes while supporting vulnerabilities, such as substance use, mental health disorders, and trauma, that often are experienced by this population.

Finally, although there is a popular discourse on the association between doulas and maternal mortality, and several studies have detailed the benefits of continuous patient support that doulas provide, there is a paucity of evidence, especially quantitative data, on the effects of doula support on severe maternal morbidity and maternal mortality. Future studies should assess the effects of doula support on the Centers for Disease Control and Prevention–defined early-warning systems to predict and reduce severe maternal morbidity (63). Studies should be randomized with the use of a direct comparison or control group. Resources and research should be directed towards enhancing high-quality evidence on doula support and patient outcomes. More and better data are needed to inform effective strategies to optimize doula–clinician partnerships.

CONCLUSION

The evidence suggests that, when doulas are part of health care teams, they improve patients' experiences and outcomes. Doula support aligns with evidence-based outcomes and reduces costs to the overall health system. Barriers to doula–clinician partnerships may be addressed with training and policy, as well as approaches that promote collaboration, communication, and accountability. Finally, the collection of data on the benefits of doulas, including patient-reported outcomes, and effective methods of collaboration should be used to address inequities in the health care system.

USE OF LANGUAGE

The American College of Obstetricians & Gynecologists recognizes and supports the gender diversity of all patients who seek obstetric and gynecologic care. In original portions of this document, authors seek to use gender-inclusive language or gender-neutral language. When describing research findings, this document uses gender terminology reported by investigators. To review ACOG's policy on inclusive language, see https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2022/inclusive-language.

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CONFLICT OF INTEREST STATEMENT

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