Flinders University | Research Centre for Palliative Care, Death & Dying

Qualitative Interviews with Registered Nurses who Work Concurrently as a Death Doula

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About this White Paper

This publication is a RePaDD White Paper and Research Report. The RePaDD White Paper and Research Report Series provide researchers and policy makers with evidence-based data and recommendations. By organising, summarising and disseminating previous and current studies, the series aim to inform ongoing and future research in palliative care, death, and dying.

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About RePaDD

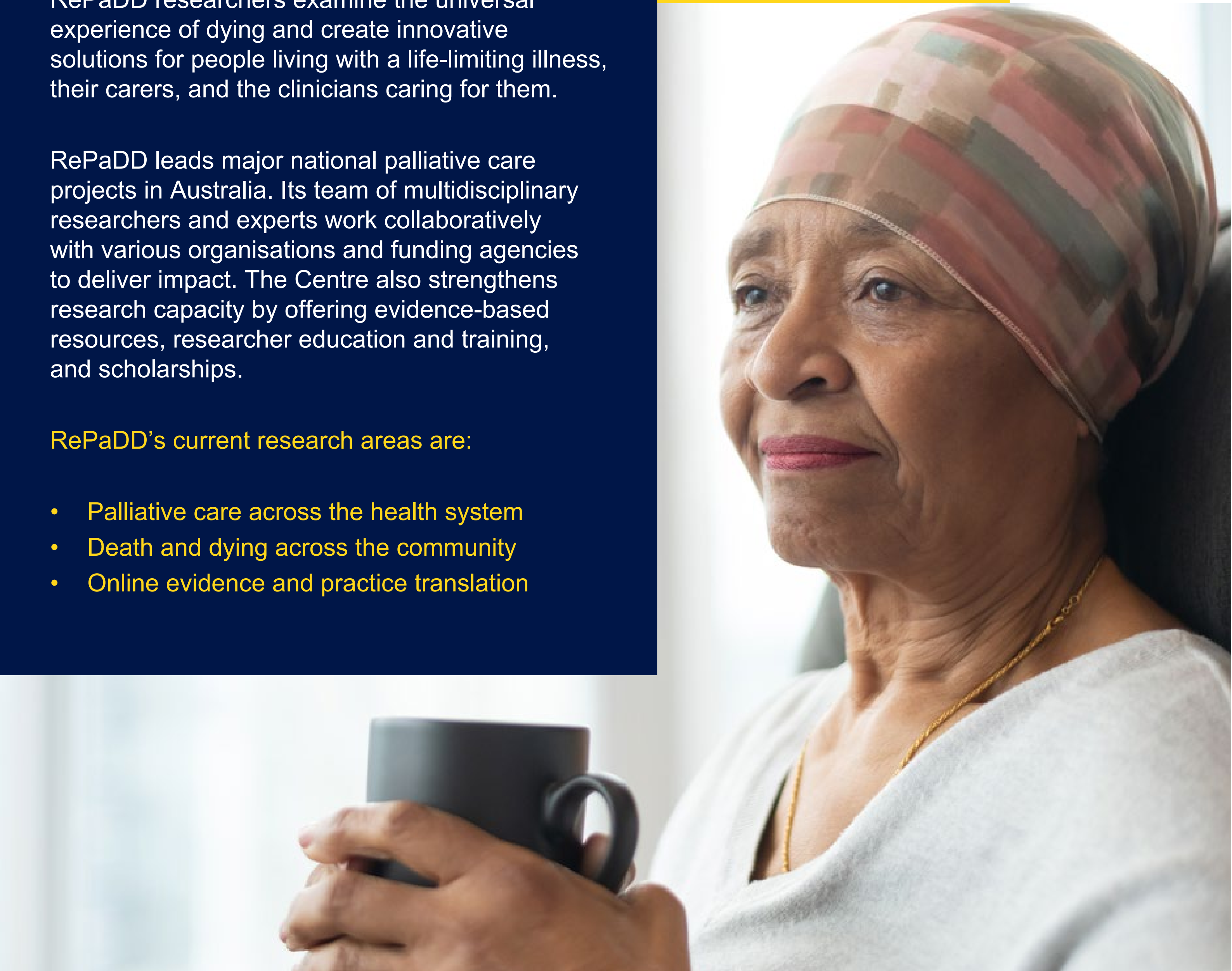
The Flinders Research Centre for Palliative Care, Death, and Dying (RePaDD) works to make a difference to the care of persons at the end of life.

RePaDD researchers examine the universal experience of dying and create innovative solutions for people living with a life-limiting illness, their carers, and the clinicians caring for them.

RePaDD leads major national palliative care projects in Australia. Its team of multidisciplinary researchers and experts work collaboratively with various organisations and funding agencies to deliver impact. The Centre also strengthens research capacity by offering evidence-based resources, researcher education and training, and scholarships.

RePaDD's current research areas are:

- Palliative care across the health system
- Death and dying across the community
- Online evidence and practice translation



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Executive Summary

The emergence and growth of the non-medical death doula movement in countries such as England, the United States, Canada, Australia, New Zealand, Sweden and elsewhere has meant that the number of those interested in taking on the role, undergoing training, and undertaking death doula research has increased.

Death doulas provide support to people at the end of life in much the same way that birth doulas provide prenatal and postnatal support. However, for registered nurses working concurrently as a death doula, tensions can arise between the biomedical approach in which their practice is situated, and the socially oriented non-medical model on which the role of the death doula is based. This dichotomy in role ethos, values and enactment requires nurses to work in a non-medical role while simultaneously working as, and holding the knowledge and skills of, a trained registered nurse.

This White Paper reports on the views and experiences of eight registered nurses working concurrently as death doulas, and how they maintained and separated expected responsibilities, legal requirements, and codes of conduct in the two roles. Through semi-structured interviews, case studies and thematic analysis, our research team found that for those registered nurses who participated in the study, most didn’t understand that nursing codes of conduct always applied and that for those working – or considering working – concurrently in a non-medical role, it is incumbent upon them to check whether their nursing registration overrides relevant death doula codes of conduct.

The study concluded that registered nurses who are interested in working concurrently as a death doula need to apply caution in developing death doula contracts with patients and families.

Ultimately, it is hoped that this White Paper will contribute to an awareness among registered nurses that the adoption of a concurrent role as a death doula should be carefully considered, and that advice should be sought from their national nursing registration organisation in view of the possible tension between the responsibilities, legal requirements, and codes of conduct applicable to each role.

Introduction

Death doulas provide support to people at the end of life similar to how birth doulas provide prenatal and postnatal support.[1, 2] Both roles have perhaps emerged in opposition to the medicalisation of birth and death and the perceived need to normalise such life events.[3, 4] The word 'doula' has its origins in the Ancient Greek as a woman 'servant' or 'slave' and historically would have been a local woman in the community helping with births and laying out dead bodies. In recent years, the emergence and growth of the non-medical death doula movement has mirrored that of the well-researched and documented birth doula role. A death doula is someone who provides advocacy, guidance and support to patients and families who are navigating dying and death.[1] Death doulas are growing in terms of the numbers of those interested in taking on the role and those undergoing training and more latterly in research arenas.[5-9] Death doulas (or end-of-life doulas) are working in many western countries such as England, the United States, Canada, Australia, New Zealand and Sweden.[10] In other cultural contexts they may not be named as 'doulas' but may work at a grassroots level in local communities supporting the dying and their families.

In previous research studies the authors have found that some people with a health background are attracted to the death doula role and that some registered nurses are working concurrently as a death doula.[11] Nursing is framed within a health or biomedical approach, whereby registered nurses work to agreed and accepted standards of education and role enactment and their practice is regulated, in Australia, by the Nursing and Midwifery Board of Australia. Equivalent organisations provide registration, regulation and oversight for registered nurses in other countries. Conversely, the death doula role reflects a social care or non-medical model, with wide variations in how the role is taught and enacted. The death doula role is unregistered without specified education or quality standards, indicating that it lacks oversight, although in most Australian states it is regulated. It is unknown whether there is equivalent oversight in other countries.

The organisations who train death doulas (and birth doulas) globally are independent, with each determining their own curricula. Death doula training is not required in order to set up a business as a death doula, there are no required hours of study or type of course that has to be attended, with each death doula deciding what they want to study, if at all. Death doulas may charge a fee or volunteer. The organisations that provide death doula training often provide ongoing support and are in fact driving the development of the death doula movement from within (in the absence of overarching umbrella organisaiton or peak body), however there are ambiguities in their philosophies and business models.[12]

With death doula research still emerging, none to date has investigated or documented the experiences of nurses who work concurrently as a death doula.

This dichotomy in role ethos, values and enactment requires the incumbent to work in a non-medical role while simultaneously working as and holding the knowledge and skills of a trained registered nurse. A pragmatist philosophy has the ethos that: "human actions can never be separated from the past experiences and from the beliefs that have originated from those experiences".[13] This resonates with two of the researchers (both experienced palliative care nurses) in considering how as a registered nurse you can realistically take off that hat (with associated experiences, knowledge and assumptions) and also work with clients in a non-medical death doula role.

Study Aims and Design

The aim of this study was to investigate the views and experiences of these nurses and how they maintain and separate expected responsibilities, legal requirements, and codes of conduct. The design of this study was informed by a pragmatist research paradigm focusing on the lived experiences and contexts in which the research participants (registered nurses who work as death doulas) are situated.[13, 14] Pragmatism would say that as individual case studies none of the registered nurses will have identical experiences, although are likely to have some shared beliefs relative to the two roles.[14] Exploratory multiple case study design[15] was employed to enable an in-depth exploration of a new, never-before studied phenomenon. As such, the researchers developed the questions based on experience gained from previous death doula research studies as well as the extensive specialist palliative care nursing experience of two of the researchers.

Between four and ten cases is considered optimum in a multiple case study design.[16] Each case contributes to the broader appreciation of this issue, as no one case can be considered “typical”.[17] Quality measures have been adopted by ensuring rich data is captured and via rigorous analysis.[18] This work has not been undertaken in isolation, and two secondary data sources speak to external validity: the study questions were informed by the authors previous survey of death doulas where this phenomenon was made apparent[11] and interviews with 20 death doulas of whom five were nurses.[19]

Of note is that in the interviews, the term ‘Australian Health Practitioners Regulation Agency’ (AHPRA) was used rather than ‘Nursing and Midwifery Board of Australia’(NMBA), however the acronym AHPRA is the common vernacular when speaking of registration. NMBA Australia and AHPRA work in partnership.[20, 21]

Sample Recruitment and Procedure

Criterion purposive sampling recruitment approaches were made to recruit those who could answer the questions under consideration and who were working concurrently in a registered nurse role and a death doula role (i.e., inclusion criteria).[22] To this end, five death doula training organisations disseminated study information (including participant information sheet) via their email lists, as did the Dying2Learn Massive Open Online Course participant email distribution list; both used previously to recruit death doulas.[11, 23] Advertisements were also placed in two national palliative care specific newsletters. Recruitment took place between October 2021 and April 2022. Anyone interested in participating in the study was instructed to contact the lead author, who provided a participant information sheet about the study. Participants were asked to read the information sheet and to sign the consent form if they were interested, returning it to the lead author before arranging an interview.

Data Collection

A total of eight registered nurses, seven from Australia and one from New Zealand, consented to participate in the study. None subsequently dropped out. Individual interviews were conducted online from November 2021 to April 2022.

The interviewer MW introduced herself to each participant (name, occupation, professional background), and reiterated study aims and reasons for the research. Interviews were semi-structured, guided by a set of questions about their registered nurse and death doula roles. Interviews ranged from 25-45 minutes, were audio and visually recorded and transcribed verbatim via a third party with a non-disclosure agreement in place. Transcripts were offered to participants for correction (none took this up) and were deidentified before analysis.

Ethical Considerations

Ethics approval was received from a University Research Ethics Committee and conducted in adherence with the National Statement on Ethical Conduct in Human Research.[24] Informed consent was gained from all participants.

Data Analysis

This study used an exploratory multiple case study design, facilitating an investigation into an unknown phenomenon.[15] Contextual variables unique to each participant (case) were explored, as well as linking themes across all cases, with data analysis consisting of two stages, within-case analysis, and cross-case analysis.[25] For the within-case analysis, each case was examined separately by the second author, transcripts were read in detail, and key information was extracted and summarised. Interview transcripts were coded using NVivo software version 12 and were coded line-by-line using open coding[26], involving conceptual groupings of similar words and sections of text, adding new codes when new concepts emerged.[27] Higher-order themes reflected the questions that were asked in interviews, with sub-themes generated inductively.[27] Axial coding was used to organise codes under the overarching categories, and refine the themes.[26]

The lead author reviewed the themes, providing feedback to the author who led the data analysis, with the coding scheme subsequently reviewed and modified. All authors then subsequently agreed on the themes. In addressing reflexivity, the authors were conscious of the need for a data-driven, inductive approach, with themes centred around participants' own words and experiences, rather than the authors' preconceptions.[28] Each participant was therefore invited to read and review their transcript and make any edits.[29] In addition, neither of the nurse researchers conducted interviews and the research assistant has no previous history in DD research and therefore no preconceptions.[30]

Results

Demographic Characteristics

Seven participants resided in Australia and one in New Zealand. All eight were registered nurses, and for half, their current nursing role involved some aspect of palliative care or end-of-life care.

Case 1: A part-time palliative care registered nurse and funeral celebrant (Australia). Death doula for four years following a few training workshops and courses. Interest generated from nursing in different roles/noted community end-of-life gaps and experienced significant personal losses, providing end-of-life care to mother.

Case 2: A registered nurse in the defence force (New Zealand). Death doula for one year following two death doula training courses. Interest generated from grief recovery course/ death doula training complemented registered nurse work in end-of-life care.

Case 3: A registered nurse in operating theatre (Australia). Not yet practicing formally as a death doula (undertook two death doula training courses). Interest generated from a profound experience with a patient at the end-of-life/a conference with a death doula speaker/attendance at death doula training course.

Case 4: A part-time registered nurse, part-time paramedic (Australia). Death doula for two years following two training courses. Interest generated from an online course/personal experience with husband/ experiences working as a paramedic, in aged care/end-of-life planning at work (home care provider).

Case 5: A palliative care registered nurse (Australia). Death doula for three years following two online death doula courses (USA & Australia). Interest generated from community palliative care role/noted gap in after-hours service/sees people at end-of-life who lack supports/sees death doula role as a service to fill this gap.

Case 6: A registered nurse in community hospice (Australia). Death doula informally for five years, and intensively for six months following an online training course. Also holds a graduate certificate in palliative care. Interest generated from nursing outreach support role (noted gaps in community)/need for support to link people to services.

Case 7: A surgical registered nurse (Australia). Death doula for 20 years (more an end-of-life volunteer) following two death doula training courses including online. Also holds a graduate certificate in palliative care. Interest generated via awareness of death doula term (that's where she fit)/working on COVID-19 ward (nurses could benefit from death doula support)/work in aged care -shocked at lack of conversation and end-of-life planning.

Case 8: A registered nurse in an aged care facility (Australia). Death doula for one year following three death doula courses including a three-month course in America. Interest generated from life coach training/ work in grief, loss/end-of-life/supports people with dementia (and family), not enough support for families at end-of-life, gap between nurses and volunteers could be filled by death doula.

Within-Case Analysis

Results of the within-case analysis can be seen in Appendices 1 and 2.

Cross-Case Analysis

Results are presented on key themes related to the participants' experiences across all cases, as well as themes unique to particular cases.[25]

Higher-order themes reflected the questions that were asked in interviews, with sub-themes generated inductively (i.e., from the voices of the interviewees themselves). Themes were:

1. interest in death doula role,
2. attraction of the role,
3. what do you do as a death doula that you can't do as a registered nurse,
4. separating the roles,
5. seeing nursing patients as a death doula,
6. monetary considerations,
7. service models,
8. future work plans,
9. AHPRA/ NMBA influence,
10. bound by nursing code (See Appendix 3).

Discussion and Implications

The individual cases represent a snapshot that reflects a newly articulated phenomenon, that of registered nurses working concurrently as a death doula, although of note is that the doula/nurse conundrum is not without precedent with the birth doula role in existence for decades. However, this study is the first to investigate the complexity underlying this unique area of inquiry.

Within-case analysis provided an in-depth look at eight individual cases that give detailed descriptions of how each registered nurse enacts the death doula role, and cross-case analysis has elicited commonalities and differences between cases.[17] There were similarities between cases, including how participants became interested in the death doula role (palliative care or end-of-life care nursing background), in noticing gaps in current local healthcare provision, in distinguishing the death doula role as non-medical, and that they would refer to health care professionals in an emergency. The majority really enjoyed the role, especially as they could spend time with people, and many wanted to transition fully to the death doula role at some point. Interestingly, most were unaware that the nursing code of conduct always applied, although equally they acknowledged that their nurses' registration in some way influenced their death doula role. Notable differences were the way in which each practiced or enacted the role, especially in relation to business models, including charging money, contracts, and insurance, a finding supported by another of the authors' studies relative to death doula models of care.[10]

Registered nurses are seeing increasing complexity in their role, including high patient to nurse ratios, and increasing care and paperwork demands, which can translate to less time at the bedside. The death doula role encompasses what some registered nurses enjoy about the caring aspects of the role[19], which may lead some to consider leaving the workforce, with death doula work as a potential way-out.[31] Viewing the death doula role in a social context, such as time spent with dying people outside of the health professional remit is an important consideration for registered nurses with such aspects seen as attractive and presumably lost from nursing. A personal experience of death has also led some to consider the death doula role and what it is they value about that caring experience, delineating the medical from the non-medical aspects of death and dying.

Nurses working in more than one role is not without precedent.[32] Historically, nurses have worked casually or part-time across more than one job and more than one employer, often for reasons including job dissatisfaction, a quest for more money or role flexibility[32], but arguably not in diametrically opposing (clinical or biomedical versus non-medical) roles. Participants in the present study did not necessarily take up the death doula role for monetary reasons, with some purely reporting altruistic motivations such as 'giving back to the community' and having another job as a registered nurse may fund this.

The death doula role appears attractive, with ‘flexibility’ and a work-life balance an advantage. Some respondents would like to further transition into the role, and four participants mentioned that this could be something they do in retirement. However, some do enjoy both roles, and arguably if death doulas were adequately compensated, nurses could swap jobs more easily, rather than working in a dual role while trying to transition across.[2] Role boundaries were difficult to maintain for some participants and very clear for others, with the clinical or biomedical role very distinct from the non-medical death doula role. One participant cited their strong personal ethical and moral code as applying more than any official rules, but not all will approach the work in that way. Grey areas do exist ethically, with some participants seeing clients as a death doula that they had cared for as a registered nurse (although it is important to note that some workplaces supported this). Interestingly the Royal College of Midwives in the United Kingdom (UK) believe that birth doulas should be directly commissioned by women, and that employment in the National Health Service presents a conflict of interest.[33]

This UK midwifery position statement is clear regarding the birth doula role, advising student midwives against working as a birth doula.[33] McWhirter[34] also describes ex-registered midwives who may be working as a birth doula, and midwives during a period of de-registration prevented from acting as doulas. When considering the registered nurse scope of practice following the interviews conducted for this study, the lead author consulted the Nursing and Midwifery Board of Australia for clarification. From this, the authors caution that registered nurses who work concurrently as a death doula should consider the legalities of their existing death doula contracts with clients, which delineate between them being present as a death doula and not as a registered nurse. Two registered nurses also mentioned that they follow the National Code of Conduct for Certain Health Workers and the ‘Australian Doula’s code of conduct’ when working as a death doula, but neither appear to apply as the nursing registration/ code of conduct overrides them. The lead author contacted all interviewees and advised them to seek advice regarding working practices and legalities of contracts.

This is indeed a grey area. Krawczyk and Rush[5] in their interviews with death doulas found:

> *“Several participants were careful to delineate that medical care could be provided by an EOLD if they were also a licensed / certified health care professional, but that it must be clear those particular services were being done under that role’s scope of practice and regulatory authority rather than as an EOLD role”.*

Some of the study participants did have separate contracts or insurance to keep the two distinct, but there may be specific implications if a client is aware that their death doula is also a nurse. Keeping nursing expertise aside when working as a death doula would presumably be challenging, in switching focus from nursing to companioning (for example) and turning off your ‘clinical’ mindset. Yet study participants were very clear in that apart from first aid or cardiopulmonary resuscitation, they would advise clients to contact a health care professional if

a medical event occurred. Interestingly though, registered nurses are likely to have a responsibility or duty of care to provide some form of medical care (dependent on the situation) rather than state that they are there in the doula role. How this responsibility of care applies when working in a non-medical role is not clear, and not apparent on either the NMBA or AHPRA websites. To consider is that while the code of conduct refers to all nursing practice in all contexts (paid or unpaid), the determination is whether they are using nursing skills in the death doula role and in what context. Although as one participant noted, "you cannot take away that knowledge and experience" and this is likely the crux of how it would be interpreted should it be challenged in a legal context. While most of our participants were not aware that they are bound by AHPRA/NMBA rules and regulations while working as a death doula, nonetheless, when considering the question, five realised that the AHPRA registration did have some influence on the way they enacted their death doula role.

The dichotomy of role philosophy and enactment will be of interest to nursing as a profession, as more registered nurses take on the concurrent death doula role globally. A national roundtable discussion was held about the death doula role in Australia hosted by the peak body for palliative care.[19] Two nursing organisations: Palliative Care Nurses Australia and the Australian Nursing and Midwifery Federation (the national nurses' union) were represented, as was AHPRA (responsible in conjunction with the NMBA for public safety and for oversight of training and quality).[12] This indicates an acknowledgement of not only the emerging death doula role, but also its' relevance to the nursing profession going forward.

To our knowledge there is little if any guidance available for registered nurses who also work as a death doula, but it is worth noting again the UK position statement advising student midwives and midwives against also working as birth doulas to "avoid any conflict between the two distinctive roles".[33] Of interest is a volunteer doula program in the United States of America where student midwives train and work as a birth doula but under a certified nurse-midwife[35] which could provide a future model for those training to be a palliative care nurse.[10] Lentz[36] has also described a self-envisaged palliative care doula model, albeit for the advanced practice palliative care nurse, and one of volunteerism. Nurses working concurrently in diametrically opposing roles is something that is likely to be occurring globally and many registered nurses will develop contracts with clients saying that they are there as a doula not a nurse (such contracts are often recommended by death doula training organisations). Any registered nurse when taking another role concurrently should carefully consider when entering into such contracts with families and seek advice from their national nursing registration organisation.

Strengths and Limitations

A major strength lies in this being the first study of its kind globally, where nurses were interviewed about working as a death doula while working concurrently as a registered nurse. A main limitation was difficulty in recruitment due to a small sample and hard to reach population, presumably as there are not yet a huge number of nurses working in this way. There may also be a possible reluctance to discuss the dual role. A further limitation is the inability to generalise findings, not transferable beyond this oceania research context due to the specificity of the cases.[18] It is likely that the experiences of registered nurses with a concurrent death doula role may be quite different in countries with different health systems and models of care, different regulatory systems, and greater death doula visibility.

Conclusions

Some registered nurses work concurrently as a death doula, perhaps as a way of transitioning away from fulltime nursing. Having more time to spend with patients and families enables flexibility to meet client needs, which has been reported as an attractive feature of working as a death doula. However, the reality of registered nurses working in this way should be considered in relation to roles and responsibilities, legal requirements, and codes of conduct. There are important implications in that nursing registration requirements override death doula codes of conduct.

In Australia, the peak body for Palliative Care (Palliative Care Australia) has developed information sheets for health professionals and consumers about death doulas. As with the UK College of Midwives, perhaps it is up to nursing registration bodies to develop death doula policies, and address practice going forward.

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Appendices

Appendix 1: Descriptive Overview of Role Enactment

Case	Role enactment			
	Role attraction	**Payment**	**Future plans**	**What do you do as DD that you can't as a nurse?**
Case 1	Exciting/flexible hours/work-life balance/DD role important in building Compassionate Communities	Yes, when engaged as Funeral Celebrant, other DD services/ some services provided free (community service)	To transition to DD role/ continue working in dual role until retirement, then part-time as DD	Encourage family discussions, prepare for EOL when they're well e.g., ACP, Advocacy, navigate, find services/attend health appointments/give time for clients to engage (unrestricted by organisational funding)/writing life stories/planning funerals or living wakes/companioning the dying/giving respite to family and friends/ more able to offer different types of support
Case 2	Enjoys Death and dying conversations/ wants to provide EOL navigation support/ a role where you can earn money and also give back to society	No, already paid in nursing role	Continue in both roles. Not looking to leave nursing / consider DD role after retirement	Nothing, as role is complimentary to nursing role
Case 3	Creating space for and educating people regarding alternatives to mainstream ways of dying. PC teams understaffed, under-resourced	Not yet practicing but will seek monetary payment	Stay in both roles for now, will eventually transition - decrease nursing role and increase DD role	Spending time with people/space to be with them, not feeling pressured to move on to the next job/working for oneself, less constraints
Case 4	Filling service gaps in EOL care (time)/ diagnosis to after death	Yes, initially voluntary until secured a grant to provide DD services/ service agreement with local council to provide EOL services /council send referrals, provides DD services for an hourly rate (paid for via home care package/ NDIS)	Transition to DD role/started DD role to avoid shift work/difficulties as no DD registration/ could do DD role full time when retired	Time (have conversations, write an ACD, help with funeral planning). As a nurse, you can only give options or resources. DD role not time limited, restricted by policy or procedure, can do what the client wishes, can 'work outside the box'
Case 5	Supporting families (knowledge as PC nurse helps)/ feel comfortable talking, giving EOL information/likes bereavement work	Sometimes - making money is not main focus. Provides free phone information and follow up appointments. Paid talk with hospital chaplains	Currently enjoying both roles/enjoys not relying on DD work as a full-time business/ may do more of the DD role after retirement	Able to see people after hours, flexibility of DD role
Case 6	interest in living with awareness, developing consciousness/ previously worked as BD/ likes supporting people during major life transitions/ DD work rewarding and needed in the community	No, although it has always been offered. Not in the DD role for an income stream, more of a gap-based service. Would be good if role was funded in the future	Wants more DD work, but still enjoys both roles (hospice, DD)/ looking forward to retirement (volunteer as a DD – community service without worrying about finances)	Much DD work is similar to nursing work at hospice, e.g., similar ethos and culture/time. As a DD, if don't have other commitments, can be fully present with the people and be with them for as long as needed.

Case	Role enactment			
	Role attraction	**Payment**	**Future plans**	**What do you do as DD that you can't as a nurse?**
Case 7	Supporting, advocating for people choosing home death/variation in DD role/feels as if have something to offer DD role (RN background)	No, but working towards it	Would like to transition fully to DD role/many nurses talking about early retirement/at point in career where could become more self-employed, independent practitioner	Have the time, not feel pressed to be moving quickly to really/connect with people/ having the scope to address whatever the client wants/as a nurse you are constrained by the organisation
Case 8	Spending time with people (holding space)/needed change from physical 'doing' role of nursing, to more of a 'being' role. Won't always be able to do physical work /Loves getting into people's homes	Yes. Has a contract for both nursing role and DD role through current employer. Invoice employer for DD business	Would like to transition fully to DD role. Committed to stepping out of nursing soon. Still working on building DD business	As a nurse, can do all the things would do as a DD, but as a DD, can't do all the things would do as a nurse. DD role is non-medical

Appendix 2: Descriptive Overview of Dual Role Aspect (Cases 1-8)

Case	Role enactment			
	Separating roles	**See patients as a DD that they've seen as a nurse**	**Influence of AHPRA**	**Aware that bound by AHPRA code when practicing as DD**
Case 1	Service brochure articulates DD service options/clear distinction of non-medical DD role/knows both scopes of practice ('never blur boundaries')/First aid and CPR trained -will administer if necessary. Phone Triple 0 if needed/ don't revert to nursing role/if client in need of a HCP will encourage them to contact GP or PC nurse/2 separate insurance policies/Follow the National Code of Conduct for Health Care Workers	No	Does not see AHPRA influencing DD role/ roles separate. Has knowledge and experiences as a nurse, but not practicing as a nurse while in DD role	No, and could not find evidence of this on AHPRA website
Case 2	Doesn't separate the two roles. DD role is complimentary to nursing role. DD role is 'nonclinical'. If medical event occurred as a DD would advocate for patient to get care they need (i.e., from another nurse)	Yes	Equivalent in NZ is the Nursing Council of NZ / Sees DD as a non-medical support role / Up to DD to know the bounds of practice within nursing role and DD role / Nursing registration is first, DD is complimentary as there is no registering body	Not answered
Case 3	Not yet practicing, however this came up in DD training/may find it challenging stepping away from giving advice or administering medication and being in that space as a DD, not a nurse/if medical event would be guided by client's wishes, e.g., call an ambulance or not	No, no plans to	Would like to keep up recency of practice as a nurse. Unaware that bound by AHPRA code when practicing as a DD, hadn't thought about it	Considers themself bound by AHPRA code anyway (a good basis for code of conduct) / Has based a lot of nursing practice on it over the years
Case 4	Work part time nursing, DD services on contract basis/don't work both on same day/doesn't organise DD referrals (client self-refers or GP)/ service agreement with the council who screen to ensure no conflict of interest)/if medical event will provide first aid, contact the ambulance, GP or own nursing service, follow plan or ACD client has in place	Yes	Being a nurse and working under AHPRA code of conduct always mindful of doing things ethically and legally/ guided by this when working as DD	Yes. Regardless of whether working as DD or not, still bound by nursing registration, even walking down the street. Always clear that DD role non-clinical. Works under own business code of conduct as well as the Australian Doula's code of conduct
Case 5	As a nurse, can advise on medication, etc./as DD, can notice that something but can't act on it, would tell client 'You need to contact your health professional' /would call ambulance in a medical emergency	No. One reason for leaving a previous role (found it messy to keep separate from DD role)	Sees AHPRA nursing code of conduct and DD role as similar. Nursing for over 40 years, has good understanding of scope of practice, know what can and won't do. Works both ways	No

Case	Role enactment			
	Separating roles	**See patients as a DD that they've seen as a nurse**	**Influence of AHPRA**	**Aware that bound by AHPRA code when practicing as DD**
Case 6	Sees roles as quite separate/RN (hospice) role more structured around medical care/DD work non-medical role (more psychosocial support)/ if medical event occurs while a DD, action will depend on what treatment is needed, e.g., refer to GP, or advise to go to hospital	Yes. Due to model of care DD work forms part of nursing work. Sometimes clients in hospice request extra support, so see them as a DD	Hadn't thought about it. AHPRA principles filter through naturally to DD role. Clear about boundaries, as a DD won't cross over to nursing role to give medications or medical advice. Own morals and personal ethics comes in more than any guidelines	No, surprised by this
Case 7	Sees it as hard to do/DD not dependent on medical model of care/ confident in nursing boundaries, keep separate to DD role/roles cross over to some degree, but mostly from knowledge base/has conversations with patients about DDs, to raise awareness/boss in nursing role not impressed has DD business on the side	No. Careful to keep that distinction	Would like to maintain AHPRA registration when transition to full time DD role, and recency of practice as a nurse	Yes. Always comes back to AHPRA code as a registered health professional, even if doing something else
Case 8	Roles set out in contract/DD role involves ACP, talking to families/staff are aware of dual role in workplace/ DD non-medical, you are on your own, not doing medications, dressings, etc., generally a supportive role/knowledge and skills as a nurse are beneficial to DD role	Yes. Dual role within the facility, staff are aware	Hadn't thought about AHPRA registration influencing DD role	No

Appendix 3: Cross Case Analysis

Theme	Description	Exemplar Quotes
Interest in the death doula role	*Professional experience in nursing or palliative care* All participants spoke of their professional nursing experience, especially in palliative care or end-of-life care, as leading to their initial interest in the death doula role. Some mentioned reaching a point in their career where they were looking for a change, saw the death doula role an extension of, or as complementary to, their nursing role, or talked about specific experiences with patients who had died, sparking an interest in the death doula role.	*"The lady, who had refused treatment, so she was moved out of the resus bay and into the main ward area. And I just thought this isn't right. I was very fortunate, I had an excellent team leader on that night. It obviously wasn't crazy busy. And so she gave me the space and the time to just be with this woman […] I still get quite emotional talking about this. I had the curtains drawn, so it was as private as we could make it. […] Nurses would occasionally pop in to see if there was anything I needed. That was great. And so she was just leaning back against me. And I was just singing to her and holding her and saying, "It's okay, when you're ready you do what you need to do." And eventually she just rested back and just breathed her last. And that was it" [Case 3]*
	Gaps in current health services Most participants discussed noticing end-of-life health care 'gaps' in their own community or organisation, such as not enough time or staff available to talk to people about end-of-life, or to link them to relevant services or after-hours care. They reported that they could potentially close these gaps through death doula work.	*"And I just realized how much of a gap it is in the community and how people really appreciated that somebody was willing to contact them and ask them about how things are going and help them link into other services or other resources. So I guess that's where my interest started" [Case 6]*
	Went to a conference or undertook training Some participants mentioned coming across the death doula role during professional training, or while attending a talk or conference.	*"I kind of stumbled across it by accident, really. I suppose I was doing some CPD to meet my registration requirements for nursing" [Case 4]*
	Personal experiences of death or loss For some participants, experiences of death and loss of loved ones sparked their initial interest in the death doula role.	*[…] "over a six month period, I had six significant losses of deaths of family members and friends and some of those were expected and unexpected and I was in a transition with my career. I was leaving a contract that I was in and then deciding what to do next" [Case 1]*
Attraction of the role	*Having end-of-life conversations and being with people* Most participants discussed their general enjoyment of the death doula role, in being fully present with people, supporting them, and having end-of-life conversations. *The death doula role is important* Some participants talked of the general importance of the role, and their views of death doulas becoming more accepted and normalised within the community and healthcare system.	*"It's the essence of why I became a nurse. I didn't become a nurse to do paperwork and all the sitting at a desk and not being with the people" [Case 8]* *"the reactions I got from people as to, "Why would you want to do this?" And it's like, "Because it's really important." [Case 7]*
	Not bound by organisation / serves the person not the system Some participants discussed the death doula role as being free from the organisational constraints faced within their nursing role, and focussed on the needs of the person, not the system.	*[…] "it's the legalities and the legislative requirements that would always stop it. And I think that's the whole reason why I think I love death doulas because they're not bound by all of that" [Case 7]*
	Flexibility, variety, and work-life balance The variety and flexibility of the death doula role was mentioned by two participants, which enabled freedom to choose their hours and establish a good work-life balance.	*[…] "Then I go for morning tea and I go for a walk and I go for a ride. I've got nice work-life balance. Yeah" [Case1]*
	Giving back to the community Two participants saw practicing in the death doula role as their way of serving their community.	*"Because I think that's important, probably for a lot of the doulas and nurses, is that feeling that you are giving to society" [Case 2]*

Theme	Description	Exemplar Quotes
What do you do as a death doula that you can't do as a Registered Nurse?	*More time* Most participants noted time as an important distinction. The nursing role was viewed as one with limited time with each person, to have conversations, to connect, and meet their individual needs. In contrast, the death doula role was seen as having little-no time constraints.	*"So, to have the freedom, to have the time with people is probably one of my biggest things" [Case 7]*
	Flexibility to meet clients' needs, less organisational constraints Some participants mentioned that the death doula role provided them with flexibility and freedom to meet clients' unique needs. The lack of organisational constraints in the death doula role was seen to widen the scope of practice with clients' wishes always at the centre of care.	*"[…]. And also to have the scope to address whatever it is that the client would like as opposed to, "Oh, I can only do this," and sort of being limited and constrained by the organization that you're with, by what you can do" [Case 7]*
	Variety/ability to offer different services Some participants mentioned offering specific services in their death doula role they could not offer as a registered nurse, such as writing life stories, planning funerals, and spending time with people.	*"So some of the other things I do in the doula role that I haven't with nursing, I guess, is writing life stories. It's if people want to tell their stories, have it written, audio taped or whatever, we can do that. Planning funerals, I mean, I'm a very good funeral celebrant. So I mean, people can plan their funerals" [Case 1]* *"The main thing is just spending time with people and not feeling pressured to move on to the next job, the next patient" [Case 3]*
Separating the roles (e.g., what do you do if a medical event occurs?)	*Death doula role is non-medical* All participants viewed the death doula role as 'non-medical', and a major way of distinguishing the death doula role from their nursing role and establishing 'boundaries' between the two. They spoke about not being able to give medical advice or administering medications in the death doula role. Some commented that keeping this distinction was not always easy	*[…] "to have that understanding that I'm not there in a medical role, I have to leave that behind. It's not a matter of giving advice or administering medication, stepping right away from that and just being in that space as a doula, not as a nurse. So I can see that's going to be something to be constantly aware of" [Case 3]* *"And with having nursing background I think it's a really good thing. Some people have a little bit of trouble trying to segregate the roles, because the doula is non-medical,….. you're not doing medications, you're not doing dressings. You can choose if you want to do personal care or not" [Case 8]*
	Follow First Aid Procedures Some participants stated that in the event of their client having a medical emergency, they would follow standard first aid procedures and/or contact an ambulance if needed.	*"So I don't revert back into the nursing role, but I have my duty of care with regards to first aid and emergency situations that I think everyone does" [Case 1]*
	Refer client to medical professional Most participants stated that in the event of their client needing medical attention, they would refer the client to a medical professional (e.g., General Practitioner or palliative care nurse) as needed.	*"If someone needs a health professional, then I just, when I'm in the doula role, I'll just say to that person that they should talk to their GP or if they've got palliative care nurses visiting, that's the question they should be asking them. So yeah, I'll always refer on to the appropriate health professional where it's needed" [Case 1]* *[…] "If they're in the hospital and something's wrong, I will get the nurse to come and be with them" [Case 2]*
	Don't separate them One participant mentioned that she didn't separate the roles, that the death doula role was complementary to the nursing role.	*"I don't. No. Well I'm a registered nurse first. Because I carry a registration. And the doula-ing (sic) and the information that comes with that and the certificate, that's icing on top" [Case 2]*

Theme	Description	Exemplar Quotes
Seeing nursing patients as a death doula	Four participants stated that they had looked after patients as a death doula that they had also looked after as a nurse.	*"Yeah. I have. And I think it has advantages and disadvantages. It can work well because if I have already seen them, then that rapport is already established and that trust is there […] So I do see clients that I have nursed and that I have provided end of life services for, but also see clients that I've not met before" [Case 4]* *"Yes. Because of the hospice. So patients initially make the first contact there and then we develop a bit of a rapport and a bond with them. And then as they go home, they have had me as a nurse before, but when I can do the doula work [inaudible], yeah, it's the home support rather than the nursing." [Case 6]*
	Some had not sought monetary payment, however had either been offered payment in the past, or planned to seek payment in the future	*"I do think that would present a conflict of interest" [Case 3]*
Monetary considerations (do you seek monetary payment as a death doula)?	Half of the registered nurses interviewed had sought monetary payment for their death doula work. Two were employed as a death doula through the same employer as their nursing role and receiving monetary payment for death doula work this way.	*"Yes. So I initially started out providing my services on a voluntary basis, and then I was able to, I think I said in the email, I secured a grant through the …………" [Case 4]*
	Some had not sought monetary payment, however had either been offered payment in the past, or planned to seek payment in the future.	*"I haven't yet. However, it's always been offered. I have volunteered, and I have said I'm happy to just be part of this, but most people have actually said, "Oh, we do want to pay you. This is amazing service and you spend a lot of time and energy and all your experience. That's definitely worth something for us" [Case 6]*
	One sought monetary payment for certain aspects of her death doula services, but not others.	*"I have, but also I haven't. Because I do have another job, it's not a specific money making thing for me. If I get a phone call for somebody to give them information, I don't charge. I've even done a couple of follow ups and I haven't charged because I just haven't. I haven't made it a money making business" [Case 6]*
Service Models	*Service agreement/brochure outlines death doula role* One participant had a service brochure outlining her death doula services, helping to clarify and distinguish her doula role from her registered nurse role.	*"I have a service agreement I have with people if they wish to engage my services formally as a doula. That clearly articulates what my service options are. So there's no graying of the waters or muddying of the waters, so to speak. I'm very clear about that. And my website makes it clear that I'm an End of Life Doula and Funeral Celebrant" [Case 1]*
	Service agreement/contract with current employer Two participants had a formal contract / service agreement in place with their current employer where they worked as a registered nurse.	*"I have a formal service agreement with xx as well. So it's all kept very separate, basically as an external contractor" […] [Case 4]* *"I went to my boss in xx and I asked her, "Can you support me in my business?" And she asked me about it and she said, "Yes, you can," and so then she gave me a contract on top of my nursing job, to do the end of life, follow-up support, and support of the relatives after the person died, before, during and after. […] So I invoice my employer for my […] end of life coaching business […] But in the moment it is a dual role in the facility, and all the staff know that that is my position" [Case 8]*
	Separate insurance policies One participant mentioned that she had separate insurance policies for her nursing and death doula roles.	*"I've also got very clear insurance policies. So I pay a lot. I have a separate RN policy with one insurance company and I have a very different insurance policy for doula and Funeral Celebrant […]" [Case 1]*

Theme	Description	Exemplar Quotes
Future work plans	*Planning to become full time death doula* Most participants planned on transitioning fully to the death doula role and were working towards building their death doula business to do so.	*"Yeah. So I guess my goal would be to work in that role full time, but I think just because it's an area that's gaining momentum, it probably won't happen for some time" [Case 4]*
	Happy working in both roles Some participants were happy working in both roles and to keep on doing so for the foreseeable future. They may also have indicated a wish to transition to full time death doula at some point.	*"At the moment, I'm really enjoying the both roles because I'm learning so much in the over 65 areas, because it is part of what I do" [Case 5]*
	Would carry death doula role into retirement Some participants liked the idea of carrying the death doula role into retirement.	*"Yeah, it would be something you could do full time when you're retired, because you'd have time to dedicate to that and not have to worry about paying bills making all those things" [Case 4]*
AHPRA influence	*Nursing ethics, knowledge, and experience influences death doula role* Most participants saw their AHPRA registration as in some way influencing their death doula role, either more generally through their knowledge and experience as a registered nurse, or more directly following the ethical and legal principles while working as a death doula.	*"[…] even if you separate the roles, you can't take away the knowledge and experience you have gained over the years as a nurse […] So I think that just complements the role in my knowledge base, but it doesn't mean that I am practicing as a nurse when I'm in that End of Life Doula role because I'm not" [Case 1]* *[…] "I work and have always worked under a code of conduct and have had professional registration, I've always been mindful of doing things ethically and legally and all those sorts of things. I guess you could say that probably the AHPRA registration, but also just in general with being a nurse, it probably does" [Case 4]*
	AHPRA registration doesn't influence death doula role Some did not see their AHPRA registration as influencing their death doula role.	*"No. Because I separate them." [Case 1]* *"I'm not sure how much it influences me. I think, much more so for the registered nurse role rather than the doula role. Yeah. And then my own high morals and personal ethics and all of that, that comes in rather than guidelines from registering bodies" [Case 6]*
Bound by the AHPRA code at ALL times	*Was not aware of this* Most participants interviewed were not aware that they were bound by the AHPRA code (of conduct) even while practicing as a death doula.	*"[…] unless [researcher name] or anyone can provide me with written evidence from the government that actually says that, then as far as I'm concerned, while I clearly have a demarcation between my roles, other than CPR and life emergency events, I don't see where that's actually written down legislatively. […] if there isn't anything in writing, I think there needs to be real caution in making a statement like that when people are working in roles like myself, when we are clearly demarcate (sic) between the two roles because it could be misunderstood" [Case 1]* *"Yeah, well it's not something I've thought about, so at this right now moment in time I'm thinking, well if I'm not a nurse, I give up my AHPRA, well I'm not a nurse, so yeah, I'm a doula. But there's no regulations for doulas anyway, as far as I know" [Case 8]*
	Was aware of this Two of the nurses interviewed were aware that they were bound by the AHPRA code even while practicing as a death doula.	*"Yeah. I think we always, as a nurse, we would have to keep that in the back of our mind. And we still have a code of conduct as a professional. And I would still see myself as a professional, as a death doula. So as a health professional, I would still say I have that responsibility. […] To me, particularly, if you're registered as a health professional, even if you're doing something else, you're still always going to come back to that, you know?" [Case 7]*
	Would follow AHPRA code anyway Some nurses mentioned that even though they were not previously aware of being bound by the AHPRA code as a death doula, they would tend to follow the code anyway.	*"I consider myself bound by the AHPRA code anyway. I find it to be a really good basis for code of conduct so it's not something that I would step outside of anyway" [Case 3]* *"Yeah, I guess it is, because regardless of whether I'm working or not working, whether I'm working as an end of life doula or not, I'm still bound by that nursing registration.[…]So I guess I'm not in there doing clinical things, but I am aware obviously that I have my own code of conduct that I work under, my business code of conduct, and I also work under the Australian Doula's code of conduct" [Case 4]*