

Birth Plans: Birth Preferences or Labor Manifesto

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Introduction

A woman's preferences for labor, childbirth, and postpartum can be communicated by means of a documented birth plan. Written birth plans have become an increasingly common component of antepartum preparation with the idea that planning provides an opportunity for education, empowerment, and developing confidence about labor [1,2]. This document, often created in childbirth education classes, aims to help women determine their birth values, become acquainted with available options for labor, and develop a list of criteria to facilitate a supportive birth environment [1,3].

The intention of the birth plan is to share preferences with a provider, allowing women to ideally exert control over events during labor, but also provide an opportunity for stronger interaction between women and their providers (physicians and midwives), especially if the woman is unable to communicate effectively under certain circumstances [4-6]. Patients and providers have viewed birth plans as manifestos of personal preferences; at times under the notion of "informed consent," they aim to attenuate power struggles between provider establishments.

Birth plans were originally introduced in the 1970s as a communication tool [4,7,8]. In the 1980s, after international criticism of an overly medicalized view of pregnancy and childbirth, the World Health Organization (WHO) went on to classify birth plans in the top category of recommended practices for making pregnancy safer [9,10].

The WHO, the American College of Obstetricians and Gynecologists (ACOG), and the American Academy of Pediatrics (AAP) all endorse attending childbirth classes, nearly all of which include preparation of a birth plan. They go on to suggest that birth plans, that have been previously discussed with providers, may serve as a vehicle for women to communicate with providers and increase satisfaction during childbirth [10,11].

Satisfaction with Childbirth

A body of evidence has elucidated several factors that positively influence patient satisfaction with birth, including: personal expectations, support, caregiver-patient relationships, and involvement in decision-making

[1,3-6,12,13]. A birth plan is meant to fulfill all of these modifiable variables in one document [7].

A randomized control trial in Taiwan assessed 296 women randomized to a birth plan versus none, and found that women with a birth plan had improved childbirth experiences, fulfilled childbirth expectations, and improved feelings of mastery and participation. These findings suggest that birth plans are an effective means of fulfilling childbirth expectations, affording a larger degree of control, and fostering an overall positive birth experience [14]. In addition, studies have suggested that if plans are not reviewed or acknowledged by the provider, women feel either let down [3,12] or that they have failed during childbirth [15]. A Swedish study of postpartum women found that women who had used a birth plan were less satisfied with their providers "listening, support, guidance, and respect" than the women who did not complete a birth plan [16].

Alternatively, birth plans could have different associations with satisfaction depending on the socioeconomic status (SES) of the patient. Given that lower-SES contexts afford fewer opportunities for control, individuals at lower levels of SES report less mastery and control than do higher-SES individuals [17]. Thus, one might expect that a woman with lower SES might feel more empowered by having a birth plan than a woman with higher SES. Additionally, women of higher SES accustomed to having control and choice in her life might feel more disappointed if the delivery does not go according to plan [17].

Controversies in Content and Value

Despite the well-intentioned goals and aspirational outcomes of birth plans, there is rarely a streamlined and organized approach to creating one, largely due to the varied sources that are used. Thirty-nine percent of birth plan content is drawn from the Internet, which includes websites of undetermined medical accuracy [18]. Furthermore, many birth plans include requests to avoid outdated procedures such as prophylactic enemas or routine episiotomies. Episiotomies have been discouraged by ACOG for the past decade [19], and national rates indicate a consistent decline (ref). The inclusion of outdated content, not congruent with standard care, possibly decreases the likelihood that hospital staff will take the document or the requests seriously. Similarly, at times, rather than being an effective communication tool, birth plans turn into unintended obstacles that create friction between providers and birthing mothers. Aragon et al. addressed

potential drawbacks of having a birth plan [20]. They note "birth plans could potentially lead to dissatisfaction, inflexibility, and a false sense of control if a birth plan was not carried out as outlined" [20]. Other studies raise the concern that women who are inflexible with their birth plans risk feeling disappointed with their birth experience when their plans cannot be implemented [15].

Controversies in Outcomes

In addition to satisfaction, studies have evaluated other outcomes felt to be important in childbirth and have been unable to demonstrate differences between women with and without a birth plan with regard to, fear, perceptions of pain or sense of control [3,12,15,16].

A study at our institution of 109 women with a birth plan demonstrated that having a higher number of specific birth plan requests fulfilled correlated with greater overall satisfaction, higher chance of expectations being met, and feeling more in control. However, it also showed that having a high number of requests was associated with an 80% reduction in overall satisfaction with the birth experience [21]. It is unclear if this discrepancy is due to women having higher expectations or a biased medical perspective. For example, birth plans sometimes risk accentuating existing disparities between providers and birthing mothers. In some overly medicalized birth environments, birth plans are viewed as a layer of protection against potential interventions [7]. Subsequently, specific language in birth plans, unrealistic expectations, and uninformed requests can lead to frustration on both sides and formation of negative views by providers of birth plans as a whole [4,5,22,23].

Grant et al conducted a survey and reported that 65% of medical personnel versus 2% of pregnant women believed that having a birth plan predicted a worse obstetrical outcome [23]. Obstetric providers are often concerned that birth plans represent an attempt to control and plan a process that inherently cannot be controlled or planned [20]. A recent study found that 33% of birth plan mothers and 26% of their attendants indicated that birth plans could lead to rigidity with potentially poor outcomes [20]. Furthermore, 29% of women and 14% of providers felt birth plans could give "a false sense of control" and "might not allow women to prepare for the unexpected" [20]. For high-risk women in particular, it has been shown that a birth plan actually intensifies the negative feelings towards the birth experience [15].

In the literature, the presence of a birth plan demonstrates varied results in interventions and outcome. A United Kingdom study demonstrated that having a birth plan was associated with more obstetrical interventions and a higher rate of operative deliveries, though this was possibly a result of their specific patient population [24]. Pain management has often been cited as the most important aspects of a birth plan [20], and women with a birth plan are more likely to be satisfied with pain relief [3]. A Scandinavian study demonstrated that though birth plans did not improve the overall experience of childbirth, there might be a beneficial effect on neonatal

outcomes [16]. Data from our institution, collected prospectively in 300 women, with and without a birth plan, demonstrated that women with a birth plan had fewer intrapartum obstetrical interventions, including oxytocin augmentation and artificial rupture of membranes. There was no difference in the use of intravenous analgesia; however, there was significantly less epidural use in the birth plan group [25].

Central Themes: Communication and the Dynamic Processes of Labor

Ultimately, the purpose of a birth plan is to promote communication, not induce friction, between providers and birthing mothers. Seeing as responsiveness plays a key role in women's care, reaping the benefits of birth plans depends on ensuring flexible, supportive discussions during both pregnancy and labor [26,27]. Some studies suggest that even when women's documented preferences are not fulfilled, they may express satisfaction with using plans, because a discussion of options is beneficial [12,13]. Whitford, et al suggest that it is the supported opportunity to discuss options for labor, and not necessarily the written or verbalized birth plan itself that may be more important [28].

Birth cannot be planned, but preferences can be shared and the provider must ensure all parties are adaptive and flexible, given the unpredictable nature of childbirth. Cook and Loomis found that when changes to a birth plan occurred, the amount of control the mother had over the changes mattered just as much as the degree of change itself [29].

Thus, implementation of birth plans should not only take into account the unpredictable course of pregnancy and dynamic process of labor, but also ensure continuous negotiations and communication among all participants involved [29]. Communication during the birthing process should acknowledge birth plans as flexible documents "evolving" with the unpredictable nature of childbirth [3].

The Outlier, Not the Norm

Today in the United States, birth plans are still the outliers, not the norm, on labor and delivery. In Scotland, the use of birth plans are endorsed at the national level and standardized to a national maternity record, which to some extent has normalized its use [28]. Similarly, some institutions in the US have also begun implementing such documents. This allows mothers to make informed choices based on reliable information and streamlines the birth plan creation process to maximize its potential as a tool for effective communication between providers and birthing mothers during the birthing process.

A Solution

We propose that the physician or midwife help integrate shared decision-making in order to help women make use of the results of the best available research to reach decisions

that incorporate the medical evidence with respect to patients' values, centered around flexibility to accommodate the patient's needs and desires. Epstein, et al have proposed a five-step process that is informed by the needs and perspectives of the patient as well as by the physician's expertise for participatory decision making [27,30]:

Step 1: Understand the patient's experience and expectations

Step 2: Build partnership

Step 3: Provide evidence by including a balanced discussion of uncertainties

Step 4: Present recommendations

Step 5: Check for understanding and agreement

The model recognizes that decision-making is only partially a rational process; it also includes elements of trust, confidence, and values [30]. We believe this model can be utilized in obstetrics during discussions on birth preferences between providers and birthing mothers.

Given that fulfillment of birth preferences appear to significantly affect patient experience and satisfaction, it may be useful to establish a standardized approach toward creating and implementing birth plans to avoid these rifts. Rather than relying on potentially unreliable information collected from the Internet, streamlining the birth plan creation process could maximize its potential as a tool for effective communication between provider and patient during birth. Incorporating a universal birth preference document, with a cascade of options, as part of routine standard of care acknowledges birth plans as flexible documents. It ensures that providers learn to look for it, and learn to adapt their practice style to safely accommodate patient preferences.

Conclusions

Birth plans have and will become more prevalent given endorsements by national organizations. Birth cannot be planned, but preferences can be shared, and the provider must ensure all parties are adaptive and flexible given the unpredictable nature of childbirth. Hence we suggest the name "birth plan" is perhaps too restrictive, and propose renaming or marketing a "birth preference" document to emphasize the iterative nature of this process. Moreover, we encourage the use and promotion of standardized evidence-based information pamphlets for women to have access to in order to inform their choices. Perhaps most importantly, the physical documents aside, providers need to be educated and encouraged to recognize that direct communication and shared decision-making is essential to facilitate and enhance women's birth experience.

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