Birth plans: definitions, content, effects, and best practices

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The first written guide for birth plans was introduced in 1980 as a means for birthing people to document their choices in the child birthing experience. The birth plan offers an opportunity for the patient and the provider to discuss the birthing process and determine how to safely accommodate patient preferences. Patient satisfaction with birthing plans is variable and may depend on how many requests they have, how many of their plans are accomplished, route of delivery, and whether complications arise during or after delivery. Unmet expectations may lead to posttraumatic stress disorder, but following a birth plan may also be protective against it. Birthing people who use a birth plan may be less likely to use epidural anesthesia, have early amniotomy, or use oxytocin. The first stage of labor may be longer when a birth plan is used; however, there does not seem to be a decrease in the length of the second stage of labor among patients with a birth plan. Some providers believe that a disadvantage of birth plans is disappointment when birth plans are not able to be followed, and others consider that birth plans interfere with professional autonomy.

Key words: birth plans, maternal outcomes, perinatal outcomes

Background

In 1980, the first guide on how to construct a birth plan was written by Simkin and Reinke and was produced by the International Childbirth Education Association.[1] This document was designed to assist expectant parents in the communication of their wishes and expectations for birth with each other, their providers, and hospital staff, highlighting the importance of shared decision-making and informed consent in preparation for birth. However, the birth plan quickly became controversial, with some professionals discarding it as an "outdated and ineffectual document."[2] Even advocates for patient autonomy in birth noted that the birth plan may undermine trust between patients and providers.[3]

In 2006, recognizing that birth plans may have eroded this trust, it was suggested that expecting parents should focus on: (1) how to feel safe and confident as a patient, (2) how to manage pain with contractions, and (3) choice of support person and delineation of requirements for that person.[4]

More recently, the World Health Organization has recognized that medical intervention in birth may negatively affect the birthing person's experience on the basis of the fact that most patients desire physiological labor and birth.[5] The organization states that birth plans need to be "individualized according to needs and preferences."[5] Developing a birth plan can be a spontaneous decision by the birthing person or may be encouraged by the provider or the facility in which they are to give birth. This communication tool between the birthing person and the birth team can also help develop realistic birth expectations. The birth plan conversation is an opportunity to use shared decision-making to help the birthing person express and explore their wishes regarding their birth.[6] During this process, the birth plan can be used to inform the birthing person about birth choices that are safe, possible, and evidence-based. The purpose of this article is to discuss the role of birth plans, detail their components, and review perinatal outcomes, patient satisfaction, provider perspectives, and best practices regarding birth plans.

Methods

A literature search was undertaken by a university librarian using the search engines PubMed and CINAHL. The

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Note from the authors: Where possible, we attempt to use the preferable terms "birthing person," "birthing people," and "pregnant people," and gender-neutral pronouns in lieu of gender-specific terminology. When studies were cited, "women" may have been specified, and thus the term was used when referencing those studies.

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searches were limited to English only and extended from database inception through July 31, 2022. A search was undertaken with the term "birth plans" encompassing various aspects of those plans. All of the abstracts were read by 2 of the authors (J.W. and E.F.M.). Full articles were obtained for relevant articles. The references of the full articles were assessed for additional articles. Finally, 28 articles were selected for this review.

Birth plan components

The discussion about the birth plan should occur between the birthing person (and their support persons if desired) and their provider early enough in the prenatal course so that options are thoroughly clarified before birth. This conversation is a good opportunity to discuss birth preferences that might not be safely achievable for the patient or for any birthing person, and if they are achievable at the facility chosen for their birth. Thus, realistic expectations for birth can be defined during this discussion. The birth plan should be considered as a guide for birth as opposed to a rigid plan. It is critical to recognize that birth preferences need to be flexible given the nature of birth. Complete control of the birthing process is not realistic nor possible.

The Journal of Midwifery & Women's Health published a simple template that can be used to help define birth preferences.[7] If no template is used or desired, the birthing person can be asked to simply write their desires and preferences for their birth. Their partner should be included in the birth plan process so that plans are shared.

Categories of items to be considered in a birth plan can be simple or quite detailed depending on the birthing person's desires for their birth experience. The preferences will also vary depending on the health of the birthing person and/or the health of the fetus. In situations of a life-limiting diagnosis of the fetus, birth plans can still provide important support and a sense of control to the patient and their birth partner.[8]

The Table illustrates sample items and categories that could be considered for a birth plan. The broad categories that may be discussed include birth location, support persons, birth attendants, birth environment, labor preferences, labor course, fetal well-being assessment, pain relief, delivery, cesarean delivery, newborn care, and special considerations.

Birth plans and patient satisfaction

Several studies and reviews have examined patient satisfaction regarding birth plans, and the results are somewhat mixed. Most studies show overall higher satisfaction rates among patients who use a birth plan compared with those who do not.[9] A systematic review demonstrated higher mean scores of satisfaction with the birth experience for women with a birth plan ($P>.01$) in 2 clinical trials; however, in a third trial, there was no significant difference in birth satisfaction ($P=.05$).[10] One consideration is that a birth plan can prompt open dialogue between the patient and the provider. Some patients described the birth plan as simply a helpful introduction to the aspects of the birthing experience.[11] Patients commented that the process of creating a birth plan was very educational in regard to their options and hospital policy, and provided an opportunity to address concerns.[12] One study showed a unanimous opinion among patients with a birth plan that it encouraged communication with their care provider and improved their birth satisfaction outcomes.[11] Conversely, another study involving primigravidas in all risk categories showed that the birth plan was often viewed as an insufficient way to promote patient participation in care because the provider either did not read it or did not reference it in making subsequent care decisions.[13]

Another overarching theme is that pregnant people with birth plans are more satisfied with the birth experience because of an increased sense of autonomy. Patient autonomy is cited as being one of the most influential factors of patient satisfaction after giving birth.[14] Patients who have experienced a traumatic birth may be more likely to use a birth plan to feel in control of decisions.[15,16] More specifically, there is somewhat of a recurring theme of satisfaction related to the percentage of birth wishes fulfilled during delivery. One study showed that having more requests on the birth plan that were fulfilled was associated with higher satisfaction ($P=.03$) and the patient having a greater sense of control ($P>.01$).[17] A systematic review showed that there was a higher rate of satisfaction among patients whose premeditated birth plans were followed.[18] Another review on birth expectations and postbirth satisfaction showed that if the birth expectations were met, the experience was more likely to be satisfactory.[18] One study of over 1000 women showed very high satisfaction scores among women with spontaneous vaginal birth who had a birth plan, compared with women with no birth plan ($P<.001$).[6] In a separate study of women whose birth plans and expectations were met, 98.7% reported satisfaction with their care overall.[19] For women who seek information about birth from sources outside of the medical profession, the degree of satisfaction is again related to how many of their expectations were actually met.[11] Even when certain aspects of the birthing process do not follow the patient's original plan, patients may still perceive a positive outcome if they were actively involved in the decision-making process with the provider.[11,14]

However, another study showed that having a higher number of requests on the birth plan was associated with an 80% reduction in satisfaction ($P<.01$).[17] When unexpected medical complications arise, which may cause more interventions, one survey showed that pregnant people had a negative perception of their birth.[18] In another study, despite undergoing fewer obstetrical interventions, the birth plan group had lower satisfaction scores compared with individuals with no birth plan.[9,20] Similarly, a separate study showed that those with a birth plan were overall less satisfied ($P<.01$) and felt less in control ($P<.01$) of their birth experience than those without a birth plan.[20] In a study of over 1000 patients, there was no considerable difference in birth satisfaction scores between women with and

those without a birth plan even after adjusting for various birth and pregnancy aspects, and the timing of the birth plan discussion with the provider also did not make a difference.[6] It is important to note that several of the studies on postnatal outcomes were cross-sectional, conducted in the postpartum period, and may be subject to recall bias.[18]

TABLE
Sample birth plan outline

Demographics:
Name
Due date
Patient contact information
Health factors OB provider

Birth location
- Home birth
- Out-of-hospital birth center
- Hospital birth center
- Hospital L&D unit

Birth environment
- Lighting
- Music
- Aromatherapy
- Clothing (hospital, personal, none)
- Space for support person(s) (couch, chair, bed, etc.)
- Photos and/or videos

Fetal well-being assessment
- Intermittent auscultation
- Intermittent electronic fetal monitoring
- Continuous electronic fetal monitoring
- Wired vs wireless electronic continuous fetal monitoring
- External vs internal monitoring for fetal heart rate and/or uterine activity

Support persons
- Partner(s) or significant other(s)
- Family
- Children
- Doula

Labor preferences
- Ambulation
- Nutrition
- Blood products
- Birthing positions
- Birth support items such as birthing ball, peanut ball, labor tub, birth stool/chair, birth rope, ruana
- Intravenous lines, urinary catheters,enemas
- Oxytocin for labor
- Religious or cultural preferences
- TOLAC
- Primary cesarean delivery
- Breech birth or options for external cephalic version
- Water birth

Pain relief
- Unmedicated
- Nitrous oxide
- IV medication
- Hypnosis
- Breathing techniques
- Meditation
- Acupressure
- Acupuncture
- Reflexology
- Massage
- Pudendal, local, cervical block
- Transcutaneous electrical nerve stimulation (TENS)
- Cannabis products
- Open to options while in labor
- Hydrotherapy

Birth attendants
- Physician, midwife (CNM, CM, CPM, lay midwife)
- Nursing staff
- Students (nursing, midwifery, medical students, and others)
- No medical attendant (freebirth)
- Religious or cultural preferences

Labor management
- Spontaneous labor
- Induction of labor (elective vs medically indicated) and methods for induction
- Rupture of membranes
- Augmentation

Delivery
- Position
- Involvement and location of support person(s) during birth
- Support person to help catch newborn
- Mirror
- Natural tearing
- Episiotomy
- Delayed cord clamping
- Who will cut the cord
- Placenta delivery
- Placenta disposal by facility or woman to take home
- Use of vacuum or forceps in delivery

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TABLE
Sample birth plan outline *(continued)*

Cesarean delivery
- Support person(s)
- Clear or solid drape
- Dropping drape
- Skin-to-skin contact and breastfeeding in OR
- Anesthesia options
- Arm free

Newborn/postpartum
- If sex is unknown, desires regarding sex announcement
- Skin-to-skin contact or dry infant first
- No separation of mother and infant "golden hour"
- Immediate breastfeeding or delayed
- Timing/routine procedures
- Vaccines, vitamin K, eye ointment
- Rooming-in
- Nursery
- Circumcision
- Pacifier
- Formula choices, if desired
- Cord blood banking
- Length of stay

Special needs with life-limiting diagnoses
- Maternal needs
- Neonatal needs
- Memory making
- Maximizing time with infant

CM, Certified Midwife; *CNM*, Certified Nurse Midwife; *CPM*, Certified Professional Midwife; *IV*, intravenous; *L&D*, labor and delivery; *OB*, obstetrical; *OR*, operating room; *TOLAC*, trial of labor after cesarean delivery.

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Birth plans and perinatal outcomes

Several studies have been conducted on maternal and neonatal outcomes and their relation to birth plans. Regarding maternal outcomes, one systematic review highlighted a study that showed that people who planned for a vaginal birth but underwent a cesarean delivery were more likely to have a fear of birth.[18] Unmet expectations during the birth process have been associated with posttraumatic stress disorder (PTSD), although several other factors are also thought to be contributory.[18] However, a cross-sectional study showed that having a birth plan that was followed was protective against PTSD following delivery.[21]

For intrapartum outcomes specifically, one study showed that women with a birth plan were less likely to use epidural analgesia compared with women without a birth plan (69.7% vs 80.3%; $P=.009$).[22] Those women were also less likely to have early amniotomy (34.3% vs 55.6%; $P=.001$) and oxytocin (42.6% vs 55.1%; $P=.010$), even in the primiparous group.[22] There was no substantial difference in the length of the second stage of labor, but the mean time of the first stage of labor was increased by approximately 1 hour for the birth plan group.[22] A separate study showed similar results, wherein patients with a birth plan were 28% less likely to have oxytocin ($P<.01$), 29% less likely to have amniotomy ($P<.01$), and 31% less likely to have a neuraxial anesthesia ($P<.01$).[20] There was no difference in the time in labor ($P=.12$).[20] For cesarean deliveries, the data are mostly positive for patients with a birth plan. According to a previously mentioned study, primiparous women with a birth plan were less likely to have a cesarean delivery (18% vs 29%; $P=.027$), with no difference in the rates of operative delivery, third- and fourth-degree lacerations, or episiotomy.[22] Another study of over 600 women also showed that women with birth plans were less likely to have a cesarean delivery (12% vs 20%; $P=.016$).[23,24] Moreover, a study of over 14,000 patients showed that a birth plan was associated with a lower cesarean delivery rate compared with not having a birth plan (26% vs 35%; $P<.001$).[24,25] In contrast, a smaller study of 300 women showed that having a birth plan was not associated with a statistically significant difference in the rate of cesarean delivery (21% with birth plan vs 16% without; adjusted odds ratio, 1.11; 95% confidence interval, 0.61−2.04).[20,24] Overall, the literature supports a lower rate of cesarean delivery among patients with birth plans.

Two studies have shown some neonatal benefits of the birth plan. Women who presented a birth plan were more likely to begin breastfeeding in the delivery room (82.4% vs 73.3%; $P=.024$).[26] Among primiparous women, the rates of neonatal Apgar score ≤ 7 were significantly lower for those in the birth plan group (8.1% vs 20.6%; $P=.010$), as were the rates of umbilical cord arterial blood pH <7.20 (8.7% vs 21.2%; $P=.011$) and need for advanced neonatal resuscitation (4% vs 15.9%; $P=.008$).[22] No considerable differences were found among multiparous women for these variables.[22] The reason for these decreased rates of complications are unclear but may be because of the lack of maternal risk factors for adverse outcomes or decreased rates of interventions such as Pitocin.

An integrative review of 13 studies identified several themes: the birth plan positively influences labor and delivery and maternal−fetal outcomes, especially in primiparous women; maternal expectations, when unmet, can cause dissatisfaction; and providers play a key role in supporting and following birth plans.[9] In conclusion, having a birth plan may be associated with a decreased rate of intrapartum interventions. It is important to note that several of these

studies were nonrandomized and therefore limited. Several of the studies also did not report demographic data, which also may limit usefulness.

Provider perspectives

There are documented maternal and neonatal benefits to having a birth plan, but the provider's perspective on the matter may sometimes be at odds with those benefits. In one study of a cohort of 77% physicians and 22% midwives from 2015 to 2016, most (66.5%) did not recommend birth plans, and nearly one-third of the providers thought birth plans were predictive of adverse obstetrical outcomes.[27] Interestingly, this study also revealed that increasing age of the obstetrical provider was associated with being more likely to recommend birth plans (P=.01),[27] and to recognize that birth plans have a positive impact on patient satisfaction (P=.05).[27] Another study revealed that 13% of obstetrical providers believe that birth plans are an attempt by the birthing person to control a process that, by nature, cannot be controlled; 13% also labeled the birth plans as problematic because of their restrictive and overly detailed nature.[12] Moreover, 6% of providers agreed that a birth plan could be associated with increased maternal anxiety and interference with patient care.[12] Only 5% of the providers in this study did not identify any disadvantages to a birth plan.[12] In contrast, 41% of the providers agreed that a birth plan is useful for education about the birth process, and 20% noted that it promotes shared decision-making.[12] Almost an equal percentage of patients and their providers (43% and 47%, respectively) reported that the greatest disadvantage of the birth plan were negative emotions such as disappointment when the birth plan was not followed.[12] Other factors to consider from the provider's perspective are the potentially different opinions and approaches to birth requests between the office physician who discusses the birth plan with the patient in the outpatient setting and the on-call physician at the time of delivery. As mentioned before, some providers may feel a loss of professional autonomy or perhaps a heightened sense of medical liability related to adherence to the birth plan.

Conclusion

The goal of a birth plan is for the patient to express their desires and preferences for labor and birth. Evidence is conflicting regarding the benefits and risks of birth plans, and studies on birth plans and their outcomes are limited by lack of diverse demographic data and thus generalizability.[10,11,17,25,26,28] The lack of demographic data also hinders the evaluation of benefits of birth plans in diverse populations. Future studies should address broad demographics to help understand how birth plans can help or hinder birth experiences.

We propose the following best practices for the use of birth plans (Videos 1 and 2):

1. Discuss birth plans and preferences with all pregnant people
2. Start discussion and documentation of birth plans early in gestation
3. Determine what is safe or feasible in the birthing facility ■

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