Whitford HM, Entwistle VA, van Teijlingen E, Aitchison PE, Davidson T, Humphrey T, Tucker J. **Use of a birth plan within woman-held maternity records: a qualitative study with women and staff in northeast Scotland.** Birth 2014;DOI: 10.1111/birt.12109.

Abstract:

Background: Birth plans are written preferences for labour and birth which women prepare in advance. Most studies have examined them as a novel intervention or 'outside' formal care provision. This study considered use of a standard birth plan section within a national, woman-held maternity record.

Methods: Exploratory qualitative interviews were conducted with women (42) and maternity service staff (24) in northeast Scotland. Data were analysed thematically.

Results: Staff and women were generally positive about the provision of the birth plan section within the record. Perceived benefits included the opportunity to highlight preferences, enhance communication, stimulate discussions and address anxieties. However, not all women experienced these benefits or understood the birth plan's purpose. Some were unaware of the opportunity to complete it or could not access the support they needed from staff to discuss or be confident about their options. Some were reluctant to plan too much. Staff recognised the need to support women with birth plan completion but noted practical challenges to this.

Conclusions: A supportive antenatal opportunity to allow discussion of options may be needed to realise the potential benefits of routine inclusion of birth plans in maternity notes.

(190 words)

Keywords: decision-making; prenatal care; parturition; birth plans; patient participation

INTRODUCTION

Birth plans, in which women document in advance preferences for their care and support during labour, were first introduced in the 1980s to help avoid unnecessary or unwanted intervention (1,2). Completed during pregnancy they can be referred to during the intrapartum period by caregivers.

Birth plans can take various forms. Some templates provide headings with spaces where women can write, some include suggestions or structured questions about aspects of care (e.g. birth positions or monitoring the baby) while others list alternatives with tick boxes. Sometimes staff encourage birth plans and/or include template sections within maternity records. Sometimes women initiate their own birth plans, perhaps drawing on parenting books or online sources (3).

Positive effects of birth plans include: (a) allowing women to exert more control over events during labour and birth (1,4); and (b) better interaction between women and their caregivers, especially if women are unable to communicate around these times (5,6). Even when their documented preferences are not fulfilled, women may express satisfaction with using plans (7), because discussion of options can be beneficial (8,9). The only randomised trial of birth plans found its introduction improved childbirth experiences, fulfilled childbirth expectations and improved feelings of mastery and participation (10).

However, birth plans are not consistently associated with fewer interventions (in part because they are used by some women to request interventions (2)) or to fulfil preferences (11,12,13), and they can have negative consequences. For example, if formatted and viewed as menu-like lists they can restrict women's choices to the options 'allowed' by service providers (2). Detailed plans have been reported to lead to staff scepticism or even antagonism, especially if they include unrealistic requests (5,14). In one small study, the introduction of a birth plan led to women having worse relationships with midwives (15) and

a reduced sense of control (16). The authors suggest that the birth plan raised expectations that were then not fulfilled.

With few exceptions (8) most research into birth plans has been conducted in settings where they were not part of routine care (either women introduced their own plans or services encouraged birth plans as a novel intervention). In Scotland, the use of birth plans has been endorsed at a national level. The Scottish Woman-Held Maternity Record (SWHMR), introduced in 2007, includes a section entitled 'Your preferences for labour and the birth of your baby' with questions and prompts to guide women to express their preferences (Box 1) (17). This presented an opportunity to investigate women's and staff's experiences with a standard birth plan, integral to a national maternity record.

Insert Box 1 here

The work reported here was part of a broader study aimed at exploring how opportunities for women to co-construct maternity records could contribute to the provision of woman-centred care (18,19). We were aware that while, in theory, all pregnant women in Scotland have the opportunity to complete this birth plan and national protocols advise staff that women's preferences for labour and birth should be discussed at around 34-36 weeks gestation (20, page 11), not all women complete birth plans (21,22).

Methods

An exploratory, qualitative, longitudinal study was carried out in two National Health Service (NHS) Board regions in northeast Scotland.

Sampling and recruitment

Women were recruited in the last trimester. Purposive sampling ensured diversity of age, place of residence, ethnicity, parity, obstetric risk factors and model of antenatal care (19).

Midwives identified eligible women and invitations were sent with an opt-out form and prepaid envelope. At antenatal clinics, researchers approached women who had not opted out and arranged antenatal interviews. Invitations for postnatal interviews were sent to the same women when the baby was six weeks old, and interviews arranged if women agreed.

A range of health professionals, including midwives working in both community and hospitals, obstetricians and general practitioners (GPs) providing maternity care, were invited to participate, and interviews were arranged with those who agreed.

Data collection

Women were interviewed during pregnancy (after 34 weeks) and, if they agreed, about 8 weeks postnatally. Interviews were held in women's homes, at university or health service premises. A conversational, semi-structured format was used, supported by a topic guide. Interviews lasted approximately 30 minutes, were audio-recorded and transcribed verbatim. Field notes supplemented the interview transcripts. Consent forms were signed beforehand.

Data analysis

A 'Framework' approach was used for analysis (23). Initial reading and familiarisation was followed by development of chart headings to reflect both project aims and emergent themes. Data were systematically summarised under the chart headings. Summaries were independently cross-checked and then discussed to ensure rigor. Contributions from midwifery and social science investigators encouraged reflexivity and challenged preconceptions to verify themes. Patterns and relationships were explored among the themes. The quotes below are identified by region ('A' or 'B'), service user ('W') or professional ('M' midwife, 'GP', 'O' obstetrician) and ID number. Information about women's parity and type of antenatal care is included.

Ethical approval was awarded by the North of Scotland Research Ethics Committee.

Findings

Characteristics of study participants

Forty two women, 21 from each region, participated in antenatal interviews and 29 completed postnatal interviews. Twenty four health professionals (nine from region A and 15 from B) participated (Tables 1 and 2).

Insert Tables 1 and 2 here

Staff and women identified a range of potential benefits to the birth plan within the SWHMR. However not all women anticipated or experienced these benefits for themselves.

Potential benefits of birth plans – women's views

Women identified potential benefits to completing birth plans. Antenatally, some were positive about documenting a plan to ensure their own preferences were respected:

> *'..... I don't want people prodding me and, you know, without my consent. So, if I had it written down somewhere that that's what I want, hopefully they'd stick to it'.* BW45, primigravida, shared care

Some women recalled documenting options presented within the SWHMR (e.g. who should cut the cord). Others had used the plan to try to avoid particular interventions (such as an episiotomy) or receive particular interventions (such as an epidural) or have a doctor endorse a specific approach to birth. This was particularly evident when women had anxieties arising from previous difficult labour experiences or were worried that their preferred options might be unavailable or discouraged by staff attending them.

> *' I need something actually written in it, signed by a doctor saying "Yes, this has already been previously discussed and it's part of the plan".'* BW39, parous, shared care, twins

'Because I'm able to write all that down in there, I feel much more at ease going in……'
AW59, parous, shared care

Some women reflected on the value of the *process* of completing a birth plan, particularly if this involved discussion with a midwife that helped them to understand their options.

'It was really quite good, because there was things ……..you know, what you want done after the baby's born …and there's stuff I suppose that you wouldn't even think of, unless you went through that.' BW56, parous, shared care

Postnatally, women who knew staff had looked at their birth plan during labour appreciated that their preferences were followed or at least discussed. Reference to a birth plan reassured women they were being taken seriously and advised appropriately.

'….it probably empowered the midwife to advise me without feeling that she was influencing against my preferences because I'd had that discussed' BW16 (recalling her first pregnancy), parous, shared care

Potential benefits of birth plans – staff views

Staff interviewees were also generally positive about having a birth preferences section within the SWHMR. Some particularly appreciated that this normalised the idea of women having birth plans and signalled the importance of services responding to women's individual preferences.

'It really helps to normalise that [birth plan], to make that something that everyone has, …and that you're entitled to.' AO26

Both midwives and doctors mentioned that the birth plan could support useful discussions with women both during pregnancy and labour. Antenatally, it could prompt and guide conversations about labour and birth options, for example, by identifying misconceptions

women might hold or alerting staff to particular concerns. It could thus support a process of shared decision-making.

> *'…someone demanding a section and you sit down and chat with them and actually it's just based because they've had a difficult experience. .....you say, 'Well, we'll make a plan for an early epidural,' .....it's just she's terrified and she had a difficult experience .....if it's been a joint discussion, a plan, they're reassured by that, that actually someone has listened.'* BO53

In labour settings, staff noted that completed birth plans could highlight areas of particular anxiety for women, which was especially important when they did not know the woman. Some commented that explicit reference to personal birth plans could reassure women and enhance communication at this time.

> *' it alerts you to things very quickly……it's something that opens up discussions ..... when somebody comes in in established labour you don't have to mess around asking … so you've got a lovely feel of what they want .....they certainly flag up areas that need to be looked at.'* AM14

Very few staff had negative views about inviting women to complete a birth plan. One obstetrician expressed concern that some women wrote overly detailed birth plans or included requests (e.g. for good communication) implying that good care would not be forthcoming unless explicitly requested. He suggested that staff might react negatively to these.

> *'….sometimes …what's been written down may look very demanding and very naïve and judgmental of the doctors….. "I don't want anybody to do anything to me without talking to me first" ……which makes it sound as though she's presuming that poor care is going to be given from the outset and that can be quite alienating.'* AO47

Challenges of birth plan completion

Although women and staff identified benefits, we also revealed a range of reasons why women might not complete a birth plan. During antenatal interviews, some women were unaware of the birth plan section in their SWHMR, or that this was intended as an opportunity for them to document their own preferences.

Most women, perhaps especially primigravidas, wanted staff support with writing their plans. Sometimes they lacked information about what they might be offered (given their particular 'risk factors' and/or local facilities and policies) or were unsure of reasons for or against particular interventions. Some lacked confidence about how to word preferences, or wanted to talk their ideas through before committing them to the record.

> *'I would prefer to write it not on my own but discuss it with my midwife and do it with her, so I could get her viewpoint and whether it's going to be helpful or not…… [I'm] unsure about what's going to actually happen and how it is done here…..*' AW36, parous, shared care

Midwives were aware of these needs. Some encouraged women to think about or make a start completing the birth plan section for themselves, and several described how discussion and support to complete birth plans was (at least ideally or 'usually') incorporated into the pattern of antenatal care.

> *'If I see someone at 32-34 weeks I say "….and it's your birth plan maybe you want to jot some ideas down" and then if they like talk it through and try to make an appointment for them to come and talk about their birth plan if that's what they'd like'* BM35

Staff also acknowledged that their intentions to discuss options and directly support women to complete birth plans could not always be realised when clinics were busy and/or staff were lacking. This point was reflected in women's antenatal interviews, as some were unsure whether or when support to complete the birth plan would be forthcoming, and others commented on the difficulties of securing sufficient time with midwives.

' I don't know is when they're going to discuss …. birth plans with me, I don't know…' BW36, primigravida, shared care

'…The hospital is quite busy for you to ask all the questions….' AW36, parous, shared care

Many of the women expressed some reluctance to make plans given the unpredictability of labour:

'I just think half of them it doesn't go to plan anyway. You can't plan a labour, so I've never planned it' AW54, parous, MW care

'there was no point being too rigid about it, because then you might be disappointed if you couldn't….' BW42, primigravida, MW care

Midwives recognised this and some explained that in antenatal discussions they would emphasise the need for flexibility and reassure women that plans could be changed during labour if necessary.

'And I tell them it's not a plan, it's a discussion, because plans never actually work, so it's just what they would like and then at the end can be changed.' BM50

However, both midwives' and women's comments suggested that opportunities to address concerns about over-committing within plans were not always made available.

Some women considered a written plan unnecessary either because they had confidence in staff, did not have strong views about particular interventions or were comfortable taking professional advice.

' if everything's straightforward, how do I want my baby's heartbeat to be monitored during labour, I'm not really sure that myself I find that a relevant question, ……. well just monitor it whatever's the best way to monitor it.' AW59, parous, shared care

I've got complete trust in the midwives, they know what they're doing.' BW49, parous, shared care

However, some women who endorsed the opportunity to complete a birth plan nonetheless did not complete one. In contrast to women who saw no need to complete a plan because they trusted staff, a few thought completing a birth plan futile because their own or others' previous experiences made them sceptical whether plans would be read or followed.

'I don't actually believe for a second they'll look at it.' BW39, parous, shared care, twins

Some postnatal interviewees had their scepticism reinforced:

'I did that [write a birth plan], but I don't think anybody was really reading them.' AW30, primigravida, shared care

Discussion

This study of experiences with a birth plan section within a routinely used, woman-held pregnancy record had several strengths. It explored the perspectives of both women and staff, and in many cases interviewed women both antenatally and postnatally. Its systematic but flexible approach to data collection and analysis benefited from multi-disciplinary perspectives. Although the study did not focus solely on the birth plan, did not make direct observations and did not attempt to pair data from specific care episodes, its insights extend knowledge about birth plan use.

Potential benefits to incorporating birth plan use into routine care were highlighted. Having a birth plan within the hand-held records had, to some extent, normalised its use. Staff and women noted that the birth plan could stimulate discussions about labour and birth options, and support communication about women's preferences and concerns. Some women used it to request particular interventions. However, the formal written invitation to complete a birth plan did not translate automatically into a genuine opportunity that all women recognised, grasped and benefited from. Some women did not complete a birth plan because they were not alerted to the birth plan section or given the necessary support to understand available birth options, express meaningful preferences, or be reassured that a completed birth plan would not jeopardise professional care if difficulties arose during labour. Thus, the benefits of birth plans depended on the availability of flexible, supportive discussions during pregnancy as well as labour.

Many of the potential benefits of birth plans have been noted elsewhere (1,2,4,5,10). Although some challenge the idea that birth plan use is always beneficial, (12-16) these studies were carried out in contexts where birth plans were not encouraged as part of routine care where staff may have been unfamiliar with the purpose or use of birth plans, have held negative attitudes towards them, or not have been able to accede to requests.

In highly medicalised environments, tensions can arise between an obstetric view of birth as risky and intervention as normal, and a more 'natural' view of birth that presents medical intervention as less desirable (1). In these circumstances, women might use birth plans as protection against unnecessary interventions, and to improve communication and control (1,2,4). Their assertive language (24) can lead to potential for frustration, unrealistic expectations and unnecessary requests (5) and caregivers forming negative views of birth plans (4,5,14).

In Scotland, national policies have emphasised the desirability of avoidance of unnecessary

interventions whilst encouraging choice for women (20). The national health service offers low intervention, midwife-led care for 'low risk' women, and a basic birth plan template is included within the standard woman-held pregnancy record. In this context we found that staff expressed generally positive attitudes about the birth plan, and talked in terms of respecting women's requests to avoid intervention where at all possible. Some women sought to use their birth plans (and/or notes in their records) to help secure interventions that they wanted but feared some staff would discourage. We suggest that perceptions of the interventional norms in the organisational context of care help explain this divergence from the original purpose of the birth plan which others have noted (2).

The question of how birth plans should be evaluated is an important one. Reflecting the initial interest in birth plans as a means of reducing obstetric intervention, experimental and quasi-experimental studies have tended to assess their outcomes in terms of rates of intervention during labour (7, 12). However, this study suggests that a narrow outcome focus can miss the point or value of birth plans. A range of features of the *way* birth plans are completed and subsequently used can be salient for their evaluation. This study encourages attention on the potential value of the processes of completing birth plans and subsequent discussions before and during labour.

The challenges related to completion of the birth plan need to be acknowledged, even when the plan is offered as part of routine care. Women's uncertainties about the purpose of birth plans, about their options and about support for completing birth plans were apparent in this study. Although staff generally recognised support for writing birth plans as part of antenatal care and were comfortable with the need for flexibility in written plans, in practice they could not always deliver these. Only one study has identified the importance of support with completion of the birth plan (25); however, concerns about the purpose of the birth plan have been raised by others (4,26,27) and reinforce the need for clarity about the purpose and flexible nature of the plan, while recognising that not all women want to complete a birth plan

or that a birth plan may not be good for everyone (16). Moreover, our study highlights that even when a formal invitation to complete a birth plan is issued by the maternity service this is not sufficient to normalise the process (28). Staff training and time for proactive communication with women may help ensure all women understand and experience a genuine opportunity that they can use effectively.

This study confirms that birth plans can serve to facilitate and enhance women's awareness of staff responsiveness to women during pregnancy and labour; however, if plans are not obviously looked at or taken seriously, women can feel let down (8,11) or feel that they have failed (16). Responsiveness is a key feature of woman-centred care (29). Clearly, a birth plan needs to be used sensitively in order to achieve this goal.

Conclusions and implications for practice

Although embedding a birth plan section in standard maternity notes has benefits, these are not always realised in practice. Women may need to be actively encouraged to consider plans and supported to complete them. A process to ensure this should be explained at an early stage to women. Staff need time and training to better work with women who might not instantly understand their options, be able to articulate what matters to them or be confident about documenting their values and concerns on an official record.

Integration of a birth plan into the standard notes reflects an assumption that the opportunity to complete a birth plan is 'a good thing'. It may be more important, however, that every woman has a supported opportunity to discuss options for labour rather than to ensure all women complete plans.

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