Deconstruction of a Birth Plan: An Evidence-Based Approach

Alexa Swailes, MD, FACOG
Breia Loft MSN, CNM, FACNM

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Objectives

Following this presentation, participants will be able to:

Identify common components of a birth plan.

Recall evidence-based literature that supports or refutes common birth plan requests.

Describe effective shared decision-making with patients as it pertains to birth plans.

Execute positive and productive conversations with patients related to birth plans.

The power of shared decision-making

Where did birth plans come from?

HISTORY & ORIGINATION

Birth Plan Trivia

- Simkin and Reinke (1980): "Planning Your Baby's Birth"1
- Opportunity for the patient, provider to discuss birthing process and how to safely accommodate patient preferences
- Acknowledges birth as a pivotal point in a woman's life, not just another day[2,3]

  "A satisfying birth will have a lasting positive effect, just as a traumatic or unsatisfying experience will have a negative one. Creating a birth plan provides the opportunity to determine personal expectations, develop relationships with providers, and share in decision making—critical components in achieving a satisfying birth experience."

SPECTRUM HEALTH

My Birth Plan

The Spectrum Health Family Birthplace looks forward to sharing in your baby's birth. To help us understand your wishes regarding your labor and delivery, please answer the questions below.

The safety and well-being of you and your baby is our top priority. Keeping this goal in mind, even if unexpected events arise, we will try to meet as many of your wishes as possible. Share this plan with your health care providers so they are aware of your preferences and can answer any of your questions. Bring a copy to the hospital when you come in for your baby's birth.

Name: _____

Your date of birth: _____

Due date: _____

Your health care provider: _____

Partner's name: _____

Baby's health care provider: _____

Childbirth education classes taken through:

- ☐ Spectrum Health Healthier Communities
- ☐ Lamaze
- ☐ Bradley
- ☐ Other: _____
- ☐ None

At the Family Birthplace, up to five people can be with you in the labor and delivery area. Please write down those who you would like to be with you in labor.

1. _____
2. _____
3. _____
4. _____
5. _____

Labor

In labor, I would like to:

- ☐ move around and change positions throughout labor.
- ☐ use a shower and/or a Jacuzzi tub if possible
- ☐ have a birthing ball available
- ☐ have a rocking chair available
- ☐ have a squatting bar available
- ☐ drink fluids during labor
- ☐ play my own music during labor
- ☐ keep the room as quiet as possible
- ☐ dim the lights in the room.
- ☐ be informed of all procedures and have time to discuss my choices in private, when possible
- ☐ other: _____

Fetal Monitoring

- ☐ I would prefer occasional, instead of continuous monitoring of my baby's heart rate, if the baby's condition allows.
- ☐ I would like to walk around during labor while the monitor is on my baby.
- ☐ Other: _____

Labor Progress

- ☐ I do not want my bag of water broken unless my baby needs special monitoring.
- ☐ If my labor is not progressing, I would like to have my bag of water broken before other methods are used to move my labor along.
- ☐ I would prefer to try changing positions or walking before Pitocin, a medicine that can help move labor along, is given.
- ☐ Other: _____

My Birth Plan

Name: _____
Partner: _____
Other Visitors: _____
Doula/Midwife: _____
Doctor's Name: _____

Birthdate: _____
Due Date: _____
Type of Delivery Planned: _____
PMH/Diagnosis: _____

I have given careful thought to my preferences during and after labor and have outlined them below.
I understand that these are guidelines only and that under certain circumstances, they may not be followed.

For Labor

Pain Management

Fetal Monitoring

During Delivery

Labor Induction

Immediately After Delivery

Postpartum/Newborn Care

In Case Of Emergency C-Section/NICU

Feeding Baby Plans

Other: _____

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Birth Plan Worksheet

NAME: _____

ATTENDANTS

I'd like the following people to be present during labor and/or birth:

- ☐ Partner: _____
- ☐ Friend/s: _____
- ☐ Relative/s: _____
- ☐ Doula: _____
- ☐ Children: _____

AMENITIES

I'd like to:

- ☐ bring music
- ☐ dim the lights
- ☐ wear my own clothes during labor and delivery
- ☐ take pictures and/or video during labor and delivery

HOSPITAL ADMISSION & PROCEDURES

- ☐ I'd like the option of returning home if I'm not in active labor.

Once I'm admitted, I'd like:

- ☐ my partner to be allowed to stay with me at all times
- ☐ only my practitioner, nurse, and guests to be present (i.e., no residents, medical students, or other hospital personnel)
- ☐ to wear my contact lenses, as long as I don't need a c-section
- ☐ to eat if I wish to
- ☐ to try to stay hydrated by drinking clear fluids instead of having an IV
- ☐ to have a heparin or saline lock
- ☐ to walk and move around as I choose

OTHER INTERVENTIONS

As long as the baby and I are doing fine, I'd like to:

- ☐ have intermittent rather than continuous electronic fetal monitoring
- ☐ be allowed to progress free of stringent time limits and have my labor augmented only if necessary

What Does the Evidence Say?

ABOUT POPULAR BIRTH REQUESTS

Popular Birth Plan Patient Requests

- No induction of labor
- No oxytocin or artificial rupture of membranes (AROM)
- Intermittent fetal monitoring (IFM)
- Eating & drinking during labor
- Alternative pushing positions
- Alternative delivery positions
- Labor in water & water birth
- No episiotomy/operative vaginal delivery
- Delayed cord clamping
- Lotus birth/keeping placenta for encapsulation
- No newborn vaccines or prophylactic eye antibiotics
- No bottles/artificial nipples
- Skin-to-skin
- Rooming-in

No Induction of Labor (IOL)

Evidence in favor of induction:

- Elevated risk of oligohydramnios, macrosomia, shoulder dystocia, perinatal and maternal mortality after 41 weeks[4]
- ARRIVE Trial: Induction at 39 weeks decreases Cesarean delivery rate (18.6% vs. 22%) & pre-eclampsia (9.1% vs. 14.1%)[5]

Evidence in favor of spontaneous physiologic birth:

- Length of labor increased with IOL: 19 hours vs 8 hours[6]

Management of post-term pregnancy:

- Surveillance
- Plan for delivery
- Non-pharmacologic ways to encourage labor

No Oxytocin or Artificial Rupture of Membranes (AROM)

Evidence in favor of oxytocin:

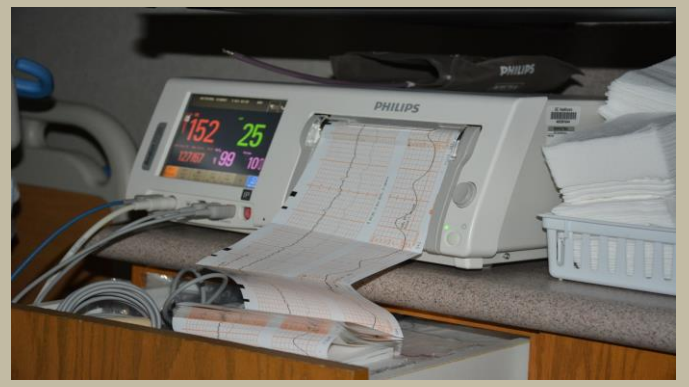
- Synthetic form of body's natural hormone
- Using oxytocin for induction or augmentation of labor does not significantly increase Cesarean delivery rate or fetal distress compared to spontaneous labor[7]

Evidence in favor of AROM:

- Shortened time from transcervical balloon catheter to delivery in patients undergoing induction of labor (14 hours vs. 16 hours)[8]
- There is no evidence that AROM increases Cesarean delivery rates or adverse birth outcomes
- There is no evidence that delayed AROM or no AROM increases Cesarean delivery rates or adverse birth outcomes

Intermittent Fetal Monitoring (IFM)

- Overuse of electronic fetal monitoring increases the Cesarean delivery and operative birth rates without reducing the rate of cerebral palsy (CP) or perinatal mortality or improving Apgar scores[9]
- ACOG: Consider IFM for low-risk women
- ACNM: IFM appropriate for low-risk women
- Know your organization's EFM policy
- Alternative: Telemetry Fetal Monitoring (blue-tooth)



Desire for Eating & Drinking During Labor

Evidence against oral intake during labor:

- 1946: "Mendelson's syndrome"

Evidence for oral intake during labor

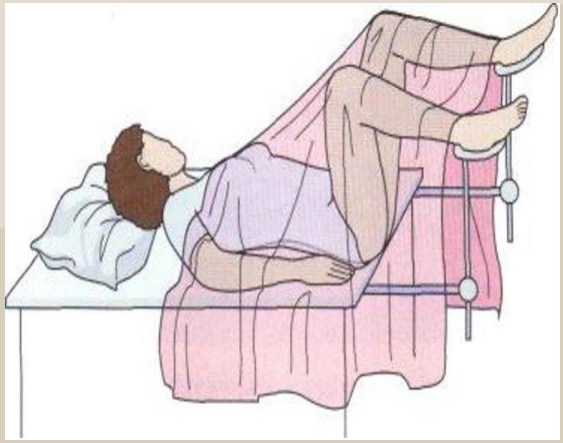
- 2013: Cochrane Review: "No justification for restriction of fluids and food in labor for women at low risk of complications"[10]

Know your organization's policy: Don't be afraid to challenge policies with evidence

Desire For Alternative Pushing & Delivery Positions

- Pushing on side can improve fetal monitoring strip.
- Physics supports knees together pushing as increasing diameter of pelvis outlet
- No evidence to support or show contraindications for pushing & delivery in different positions
- Evidence that spontaneous pushing vs. Valsalva pushing does not decrease second stage[11]

Pushing Positions: Knees Together/Ankles Apart Vs. Lithotomy:



Labor in Water & Water Birth

Evidence in support of water birth:

- Shorter labor, increased patient satisfaction, improved pain control without compromising neonatal outcomes (but higher incidence of postpartum hemorrhage)[12]
- Nursing education and detailed hospital protocols promote safe outcomes in water birth[13]
- ACOG Committee Opinion: "A woman who requests to give birth while submerged in water should be informed that the maternal and perinatal benefits and risks of this choice have not been studied sufficiently to either support or discourage her request."

Evidence against water birth:

- Increased risk for perineal lacerations with water birth[14]
- Slight increase in infection risk[15]

Episiotomy

- Evidence in support of routine episiotomy:
  - None
- Evidence against routine episiotomy:
  - Systematic review/meta-analysis, 2005:
  - Does not improve severity of laceration or postpartum pain
  - Does not prevent fecal or urinary incontinence
  - Does not prevent sexual dysfunction

> *"Evidence does not support maternal benefits traditionally ascribed to routine episiotomy. In fact, outcomes with episiotomy can be considered worse since some proportion of women who would have had lesser injury instead had a surgical incision."*[16]

- Episiotomies have decreased from 34% to 8.4%[17]
- ACOG Practice Bulletin, 2016: "Obstetrician-gynecologists should take steps to mitigate obstetric lacerations during vaginal delivery rather than using routine episiotomy."[18]

Operative Vaginal Delivery

Evidence in support of operative vaginal delivery (vs. CD):

- A low forceps delivery had better neonatal outcomes vs Cesarean delivery, no difference between forceps and vacuum assisted for neonatal outcomes[19]

Evidence against operative vaginal delivery (vs. SVD):

- Operative delivery is associated with increased incidence of postpartum hemorrhage, perineal and vaginal lacerations, neonatal intracranial hematoma[19]

Delayed Cord Clamping

- Evidence for delayed cord clamping
  - Decreased incidence of fetal bradycardia[20]
  - Increased hemoglobin levels at birth, increased iron stores in first 6 months of life without substantial increased risk of postpartum hemorrhage or retained placenta[21]
  - Reduced risk of neonatal death prior to hospital discharge[22]
  - No difference in maternal or infant outcomes for delayed vs. immediate cord clamping in Cesarean deliveries[23]
  - No difference in fetal outcomes including anemia with DCC, cord milking, ICC[24]

- Evidence against delayed cord clamping:
  - Small increased incidence of jaundice and need for phototherapy

Lotus Birth & Placental Encapsulation

Lotus Birth/Umbilical Non-Severance

- Practice of leaving placenta and umbilical cord intact until natural separation occurs
- Focuses on the principal of nonviolence
- It originated from Claire Lotus Day while pregnant in 1974 questioned the practice of cutting the umbilical cord after birth because chimpanzees did not practice this. She transferred this model over to human birth citing that babies know when the separation from the placenta needs to occur.

Lotus Birth Evidence

- Evidence in favor of lotus birth:
  - None
- Evidence against lotus birth:
  - Infection
  - Sepsis
  - Jaundice[25]
- If patient insists on lotus birth, discuss ways to mitigate infection: good handwashing, adequate skin cleansing of baby, proper care of placenta in impermeable carrying bag with proper additives[25]

Placental Encapsulation/Ingestion

- Encapsulation is a popular method of consumption which involves steaming and drying the placenta and placing it into capsules for consumption by the new mother.
- Other ingestion methods include cooking, drying and for the new mother to eat larger pieces in the first 2-7 days postpartum.

Placenta Ingestion Evidence

- Evidence supporting placental ingestion:
  - None

- Evidence against placental ingestion:
  - Does not reduce postpartum depression or decrease healing time[26]
  - Risk of infection in setting of chorioamnionitis or GBS+ [26]
  - Moderate amount of minerals such as iron, selenium, copper, zinc were found in human placenta, but also trace amounts of lead, arsenic, mercury, & uranium[27]
  - No evidence that supports increased postpartum energy level[28]
  - No changes in levels of hemoglobin, ferritin, or transferrin in RCT[29]

- CDC: placental ingestion should be avoided owing to inadequate eradication of infectious pathogens during the encapsulation process

Newborn Birth Plan Requests

- No vaccines or prophylactic eye ointment
- No pacifiers or bottles
- First assessment on mom while skin-to-skin
- All exams & procedures completed in room

No Vaccines Or Eye Ointment In Hospital

- Vitamin K:
  - Used to prevent intracranial bleeding until baby can produce Vitamin K-dependent coagulation factors[30]
  - Vitamin K has poor placental transfer, neonatal levels low[30]
  - Deficiency previous cause of classic hemorrhagic disease of newborn[30]
  - Parent's trust is gone: no circumcision[31]
- Hep B:
  - AAP recommendation: start the series!
  - Often silently carried in adults, including mother
  - 90% of infants infected at birth develop chronic disease
  - Hold if low birth weight (<2kg) or premature infant at pediatrician/NICU request, administer at 1 month
- Erythromycin eye ointment:
  - Protects against neonatal conjunctivitis and gonococcal ophthalmia neonatorum which can cause corneal scarring, ocular perforation, and blindness as soon as 24h postpartum
    - GON 0.2-1.6 cases/100,000 live births
  - No evidence of harm, avoids chemical conjunctivitis associated with other available agents (ocular gentamicin, silver nitrate)

No Bottles or Artificial Nipples

- Evidence of harm:
  - Nipple confusion can occur if artificial nipple is introduced too soon, but there are certain times a pacifier can help infants and promote breastfeeding[32]
  - Early and frequent breastfeeding is best way to promote stable blood sugar in baby even in premature infants or infants of diabetic moms[33]
- Need to follow mom's preference and make recommendations using shared decision-making method.

Rooming In & All Exams/Procedures in Mom's Room

- Baby rooming-in increases patient satisfaction, increases breastfeeding rates, decreases baby falls[34]
- Rooming-in can increase maternal fatigue and have a negative impact on maternal/infant bonding if not implemented in a flexible way[35]
- Immediate and sustained skin-to-skin contact increases thermoregulation, decreases fetal and maternal emotional distress (i.e. baby crying, fidgeting) during procedures/exams[36]

Navigating a shared decision-making birth plan discussion

1. Know your stuff including hospital policies
2. Anticipate common questions
3. Use non-confrontational verbiage
4. Don't be afraid to inform patient that your practice/organization can't meet their desires & offer alternatives.

Maintaining composure during the Q&A session is essential for relationship building with your patient. Consider the following tips for staying composed:

- Actively listen
- Pause and reflect
- Sit down in room
- Maintain eye contact
- Reassure patient care discussions will happen throughout the labor & can be fluid

Birth Experience Impact

- Birth trauma
- PTSD
- Perinatal depression
- Difficulty bonding with baby
- Fear before and during next pregnancy & birth

These outcomes can be mitigated or avoided by making sure patients have a voice and are active participants in their own birth experience

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Thank you!