

Avoiding the Birth Plan Curse: Shared Decision-Making

Amanda Williams, DNP, CNM, FACNM, PMH-C

Certified Nurse Midwife, UTROP-Regional One Health, Memphis, TN

Adjunct Faculty, UTHSC College of Nursing, Memphis, TN

Learning Objectives

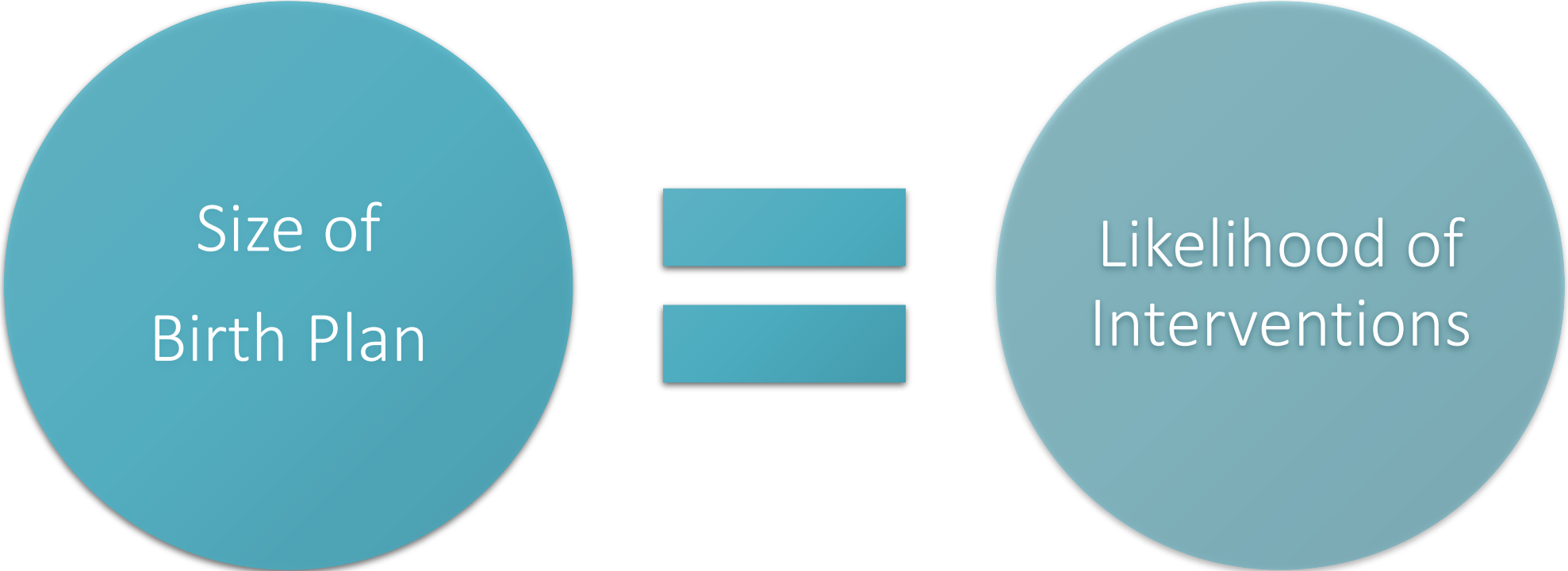
- Define Shared Decision-Making (SDM) and describe its core components – best available evidence, clinical expertise, and patient values – in the context of intrapartum and antepartum care.
- Explain the ethical and professional foundations of SDM in maternity care, including respect for autonomy, informed consent, trauma-informed care, and person-centered practice.
- Describe the purpose, structure, and common elements of a birth plan, including preferences regarding:
 - Labor environment and support
 - Pain management options
 - Fetal monitoring
 - Induction or augmentation
 - Operative delivery
 - Immediate newborn care
 - Contingency planning for complications
- Integrate birth plans into collaborative interprofessional care, clarifying how midwives and physicians can align communication and counseling to provide consistent messaging
- Apply shared decision-making frameworks to common obstetric scenarios, such as:
 - Induction of labor
 - Trial of labor after cesarean (TOLAC)
 - Cesarean
 - Epidural analgesia
 - Management of labor dystocia

Learning Objectives

- Identify barriers to effective SDM in labor and delivery settings, including time pressures, acuity, institutional policies, cultural differences, burnout, implicit bias, and health literacy.
- Demonstrate communication strategies to address discordance between patient preferences and evolving clinical circumstances while maintaining trust, psychological safety, and team cohesion.
- Distinguish between flexible preferences and fixed refusals in birth plans, and outline strategies for documenting and revisiting decisions when clinical conditions change.
- Reflect on how professional role, training, and institutional culture influence counseling practices, risk framing, and patient autonomy in maternity care.
- Develop practical approaches to documentation of SDM, including discussion of risks, benefits, alternatives, and patient-informed preferences.





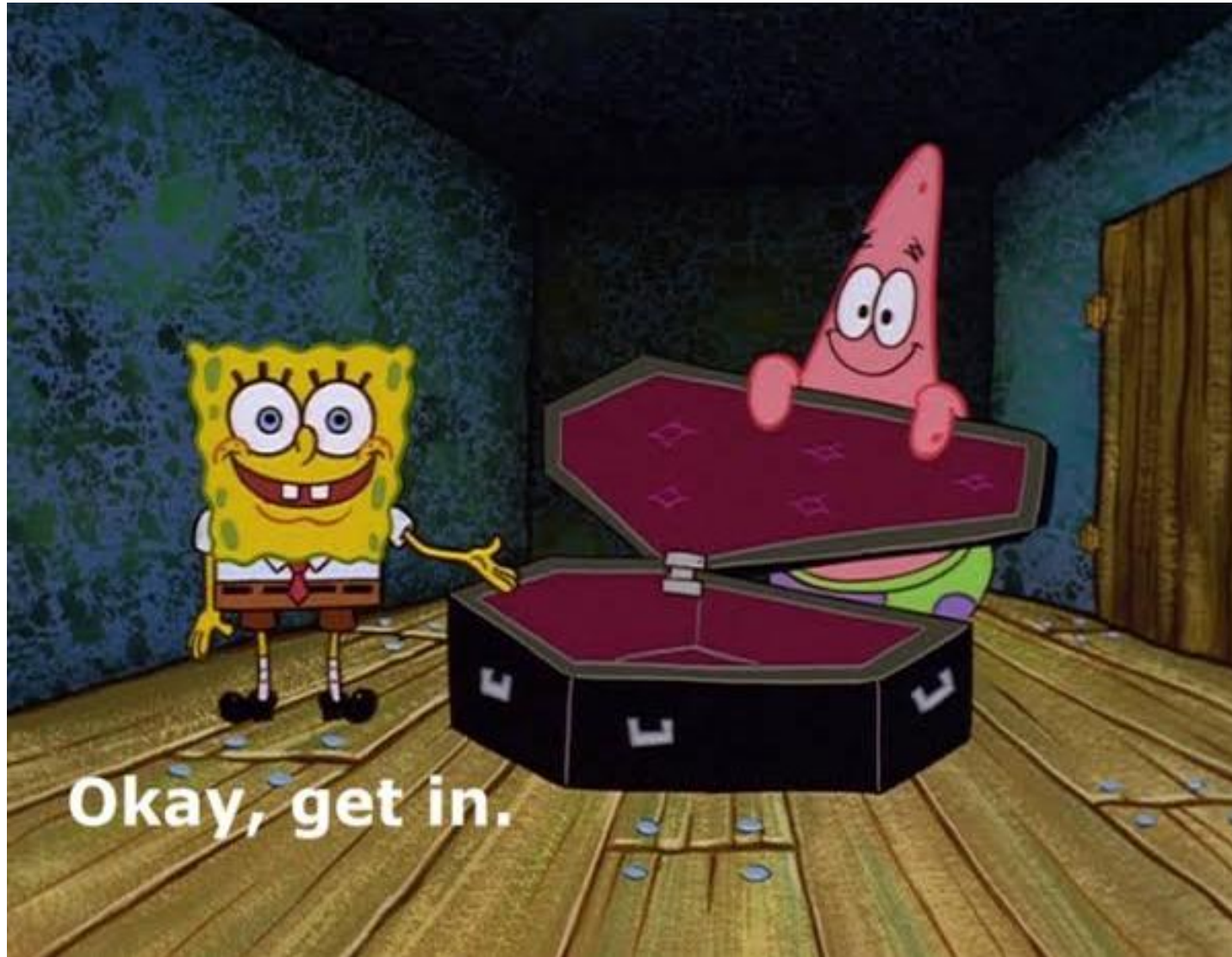


A diagram consisting of two teal circles connected by an equals sign. The left circle is a darker shade of teal and contains the text 'Size of Birth Plan'. The right circle is a lighter shade of teal and contains the text 'Likelihood of Interventions'. The equals sign is composed of two horizontal teal bars.

Size of
Birth Plan



Likelihood of
Interventions



Okay, get in.

Partnership/Collaboration

Foundational to patient-centered care

Philosophy and core values

- self-determination and active participation
- respect
- informed consent, informed declination
- trauma informed care
- respect for autonomy and justice

Communicates

- choices, health information, values, and priorities
- early, effectively, and frequently

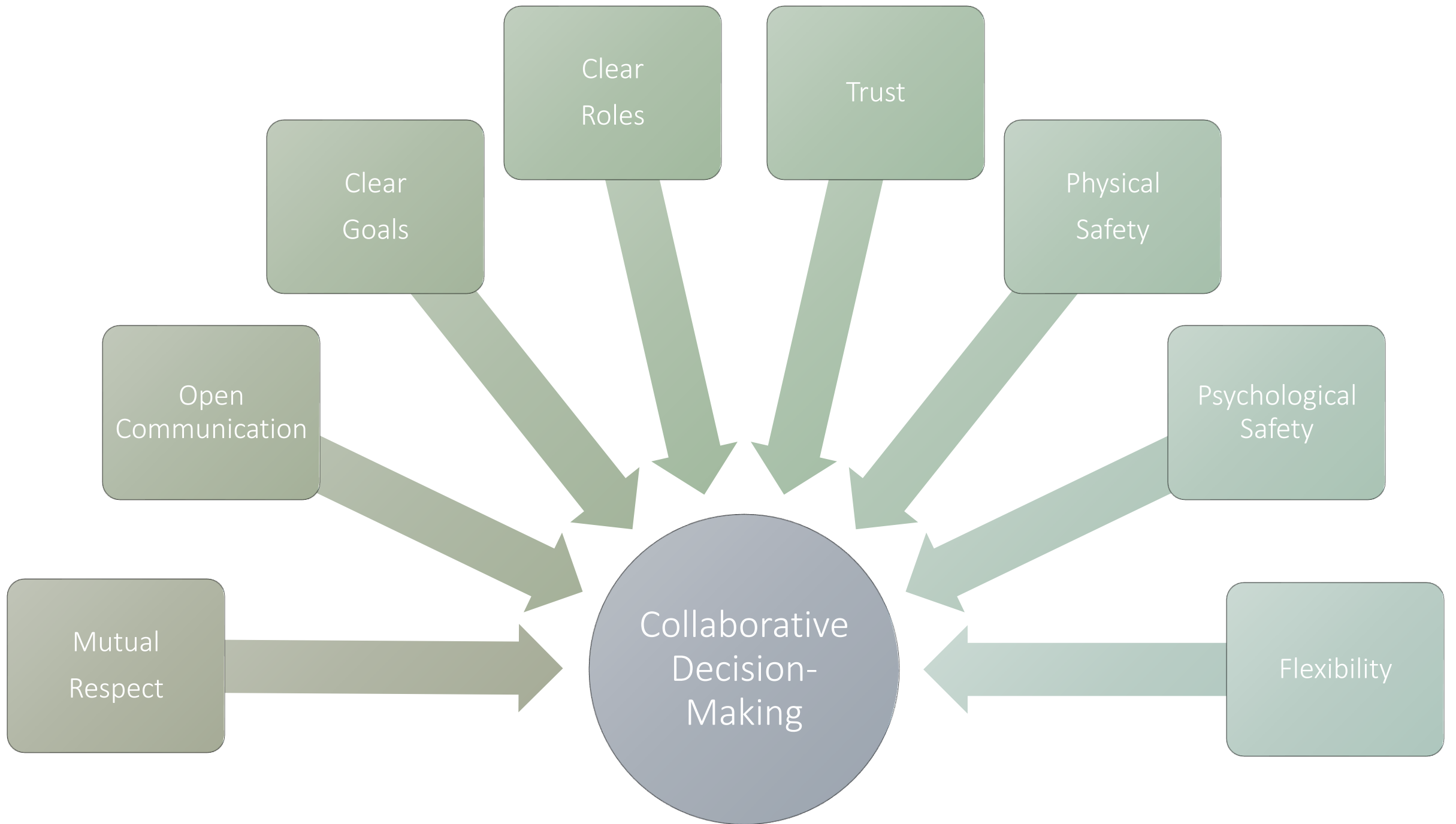
Promotes

- safe, quality, and evidence-based care

Anticipatory guidance

- open, objective, and culturally sensitive manner

Shared Decision-Making



Shared Decision-Making

Provider

- acknowledges their values, biases, and priorities
- acknowledges patient as the primary decision making
- acknowledges importance of equity, antiracism, and social justice
- acknowledges barriers for marginalized communities
- contextualizes decisions
- creates a safe, inclusive environment
- recognizes and respects the patient's perception of health promotion and threshold of risk tolerance
- recognizes coercion and abandonment are unethical
- offers ethical referral to consultation or appropriate provider

Patient

- experts on their own body and lived experience
- decisions based on own values and priorities
- retains right to decline recommendations

Provider and Patient

- accept mutual responsibility for the outcomes of their choices

US maternity care is complex and procedure intensive

Competing evidence makes decision-making nuanced and involved

Pregnant people may have limited knowledge and limitations created by social drivers of health



Shared Decision-Making

NO

present choices

obtain informed consent

explain the potential advantages
and disadvantages of each option
(possibly with bias)

YES

engage respectfully and without judgement

examine values and preferences

involved early and at all stages, especially when decisions are
difficult or unclear

recommend options/alternatives consistent with clinical history

explore current knowledge and opinions about health
promotion and risk reduction

convey multiple options for care when the probable outcomes
are beneficial

evaluate decisions **with them** and, when appropriate, their
family members

Shared Decision- Making

Decision Aids/Communication Tools

- provide holistic review of options and outcomes
- offer priority and value clarity
- increase patient satisfaction
- decrease decisional conflict
- improve knowledge
- facilitate value and culturally consistent decisions

Process

- document in the medical record

Decisions

- reevaluate as plan of care and patient priorities evolve

Decision Aids

Example

Induction, VBAC, Pain Medication, My Birth Preferences

<https://www.partnertodecide.org/decisionaids>

Evaluation of DA Quality

<https://www.hca.wa.gov/assets/program/how-to-identify-high-quality-pda.pdf>

<https://decisionaid.ohri.ca/IPDAS/>



Timing and Tone

Before Visit

anticipatory guidance

resources to review prior to discussion: QR codes or infographic

During Visit

Three-Talk Model: *Team talk* → *Option Talk* → *Decision Talk*

BRAIN Model

After Visit

resources for review: diagnosis, treatments, and a summary of discussion

online resources

means of contact for follow-up questions

summary of discussion for the care team



Timing and Tone

Team talk

beginning of discussion

introduce patient autonomy, priorities, preferences and goals of care

collaboration emphasized

establish a supportive environment

include support people and family, as desired

agree on agenda to prioritize topics - include anticipated length of discussion

time reserved to answer questions



Timing and Tone

Option Talk

- compare options based on risks, benefits, and consequences
- consider context of the patient's preferences and goals
- option of no treatment included routinely
- confirm patient's treatment goals and address misconceptions
- use numerical data to describe risks and benefits
- risks and benefits framed positively and negatively
- verify patient understanding regularly:
 - teach back
 - chunk and check
 - ask-talk-ask

Timing and Tone

Decision Talk

make a joint decision and timeline for plan review

provider clearly states decision and next steps

reassure the patient may review their decision or change their mind at any time, if desired

document decision in EMR, including what the patient valued as important factors in their decision-making



TABLE 1

Recommendations for Presenting Numerical Data During Shared Decision-Making

Recommendation	Discussion points
Use a mixture of numbers and pictures	Numerical rates with pictograms or icon arrays Positive and negative framing at the same time
Use numerical data to describe risks	Terms such as risk, rare, unusual, and common can be interpreted in different ways
Use absolute risk rather than relative risk	Risk of an event increases from 1 in 1,000 to 2 in 1,000, rather than the risk of the event doubles
Use natural frequencies	Use numerals (10 in 100) rather than percentages (10%)
Be consistent when using data; use the same denominator comparing risk	7 in 100 for one risk and 20 in 100 for another, rather than 1 in 14 and 1 in 5

BRAIN Decision Making Tool for a Better Birth Plan

What is the decision I need to make?

TIME How much time
do I have or need?
Is it an emergency?

OPTIONS What are my options?
Remember you have
the **RIGHT** of choice

B

Benefits What are the benefits of the suggested course of action?
Consider benefits to both you and your baby.

R

Risks What are the risks associated with this decision? Any side effects?
Remember that different people will weight the benefits and risks differently

A

Alternatives What other options are available?

I

Intuition How do I feel about the suggested course of action? Often our subconscious
quietly analyses the information in a way that our conscious brain can't.

N

Nothing What if I do nothing? What if we wait for an hour, a day, or a week?

BIRTH PLAN



Your Name _____ Ob-Gyn Name _____
 Ob-Gyn Clinic _____ Ob-Gyn Phone Number _____

MEDICAL CONDITIONS

☐ Anemia ☐ Oligohydramnios ☐ ST-positive
☐ Diabetes ☐ Placenta previa ☐ Medications _____
☐ GBS-positive ☐ Polyhydramnios ☐ Allergies _____
☐ Gestational Diabetes ☐ Pre-eclampsia ☐ Other _____
☐ High Blood Pressure ☐ Previous C-Section _____

LABOR

Planning for a: ☐ Hospital delivery ☐ C-section
 Support people allowed in L&D room: ☐ OK ☐ No OK
 Medical Students/Residents: ☐ OK ☐ No OK

Induction methods: ☐ Pitocin ☐ Prostaglandin
 Anesthesia: ☐ Epidural ☐ Spinal
 IV: ☐ Saline lock ☐ None (SBO negative and no pain medication)
 Pain management: ☐ Epidural ☐ Nitrous oxide
☐ Breathing techniques ☐ Massage ☐ Hypnotherapy
☐ Counter-pressure ☐ Acupuncture

DELIVERY

Delivery position: ☐ Lying on back ☐ Lying on side
☐ Squatting ☐ Kneeling on floor
☐ Standing/kneeling ☐ Water birth
 Delivery interventions: ☐ Forceps ☐ Vacuum ☐ None if possible
 Warm compress on perineum: ☐ Yes ☐ No
 Episiotomy: ☐ Yes ☐ No ☐ No preference
 Cord blood banking: ☐ Yes ☐ No ☐ No preference
 Keep the placenta: ☐ Yes ☐ No

FOR BABY

Skin location: ☐ Yes, Mid First ☐ Yes, Partner First ☐ No preference
 Delayed Clamping: ☐ Yes ☐ No
 Cord: _____
 Vaccinations, vitamins and medicine: ☐ Hepatitis B ☐ Vitamin K ☐ Erythromycin
 Feeding: ☐ Breastfeeding ☐ Bottle, Donor Milk
☐ Bottle Formula ☐ Combination
 First bath: ☐ Delayed ☐ Bathing right away
 Circumcision: ☐ Yes ☐ No ☐ No preference
 Hernia: ☐ Open request ☐ No

IN CASE OF C-SECTION

Hospital setting: ☐ Yes ☐ No
 Cesarean: ☐ Full ☐ Open ☐ Lowered
 Hatching device: ☐ Out of my view ☐ No preference
 Gentle Cesarean: ☐ Yes ☐ No preference

ADDITIONAL NOTES/COMMENTS

BIRTH PREFERENCES

PERSONAL DETAILS

NAME: _____
 PARTNERS NAME: _____
 DOCTOR/MIDWIFE: _____
 DUE DATE: _____
 BABY'S SEX: ☐ BOY ☐ GIRL ☐ SURPRISE
☐ THIS IS MY FIRST BIRTH ☐ HAVE GIVEN BIRTH BEFORE

HEALTH INFORMATION

☐ GROUP B STREP
☐ GESTATIONAL DIABETES
☐ HERPES
☐ RHESUS NEGATIVE
☐ ALLERGIES
☐ ANY OTHER

ENVIRONMENT

☐ DIM/NATURAL LIGHTING
☐ CALMING MUSIC/PLAYLIST
☐ MINIMAL INTERUPTIONS
☐ WEARING MY OWN CLOTHES
☐ LIMITED STAFF (NO STUDENTS)
☐ AS FEW CERVICAL EXAMS AS POSSIBLE

PAIN RELIEF

☐ PETHIDINE ☐ BREATHING EXERCISES
☐ GAS AND AIR ☐ AROMATHERAPY
☐ EPIDURAL ☐ MASSAGE
☐ TENS MACHINE ☐ BATH/WATER BIRTH
☐ HYPNOSIS ☐ POSITIVE AFFIRMATION
☐ OTHER: _____

BIRTH POSITIONS

☐ SQUATTING ☐ BIRTH BALL
☐ ON BACK ☐ BIRTH STOOL
☐ STANDING ☐ HANDS AND KNEES
☐ ON SIDE ☐ BIRTH POOL

DELIVERY

☐ VAGINAL ☐ WATER BIRTH ☐ VBAC
☐ C-SECTION ☐ HOME BIRTH
☐ AVOID INDUCTION
☐ PREFER WATERS BREAKING NATURALLY
☐ OPEN TO ALTERNATIVE MEDICATIONS
☐ BREATHE BABY DOWN
☐ BE COACHED THROUGH PUSHING
☐ TEAR NATURALLY
☐ PREFER EPISIOTOMY
☐ USE MIRROR TO SEE BABY'S HEAD
☐ FEEL HEAD WHEN CROWNING

AFTER BIRTH

☐ IMMEDIATE SKIN TO SKIN
☐ DELAYED TESTS ON BABY AFTER GOLDEN HOUR
☐ TRY TO BREAST FEED
☐ DELAYED CORD CLAMPING
☐ PARTNER TO CUT CORD
☐ STAFF TO CUT CORD
☐ PARTNER TO ANNOUNCE GENDER
☐ WIPE BABY DOWN
☐ LEAVE VERNIX ON BABY
☐ PHOTOS TAKEN
☐ NATURAL PLACENTA DELIVERY
☐ INJECTION TO DELIVER PLACENTA

EXTRAS

ACOG-Inspired Birth Plan Template

Name: _____ Baby's doctor: _____
 Care provider: _____ Type of childbirth prep: _____

Labor

☐ I'd like to move around as I wish
☐ I'd like to drink fluids
☐ I prefer an IV line for fluids and medications
☐ I prefer a heparin or saline lock for fluids and meds
☐ I don't have an IV or lock preference

I'd like the following individuals with me during labor and/or delivery:

It's ☐ OK ☐ not OK
 for medical students and/or residents to be present during labor and delivery.

I'd like to try utilize the following pain-relief options:

☐ Birthing ball ☐ Warm shower or bath
☐ Birthing stool ☐ Massage
☐ Birthing chair ☐ Counter pressure
☐ Squat bar

Anesthesia Options

☐ Do not offer anesthesia during labor unless I specifically request it
☐ Do not discuss anesthesia options with me
☐ I don't know if I want anesthesia. Feel free to discuss options with me

Delivery

☐ Avoid episiotomy unless 100% necessary
☐ I've made arrangements for storing cord blood

Drug-Free Birth Plan Template

Birthing Individual: _____ Partner: _____ Doula: _____
 Allergies: _____
 Medical Need-to-Knows: _____

STAGE 1

☐ Free movement
☐ Tub or shower
☐ Birthing ball
☐ Dim lighting
☐ Limited cervical checks
☐ If labor slows, exercise patience
☐ No pain meds
☐ No Pitocin
☐ No membrane sweep
☐ Allow bag of waters to naturally rupture

STAGE 3

☐ Immediate skin-to-skin
☐ Delay cord clamping
☐ Save cord blood
☐ Delay vitamin K, eye ointment & Hep B vaccine for 1 hour
☐ Deliver placenta naturally (expectant or physiological management)

STAGE 2

☐ Choose labor positions
☐ Limit hospital staff
☐ No epidural
☐ Mirror to witness birth
☐ Saline lock in lieu of IV, if needed
☐ No continuous fetal monitoring
☐ No episiotomy

NEWBORN CARE

☐ Exclusive breastfeeding
☐ No pacifiers
☐ No formula
☐ Lactation support requested
☐ Delayed bathing
☐ Room-in with baby

Use this birth template to help create your individualized plan!

Birth Plan

1st Stage

No drugs offered; no active management of labor

Intermittent monitoring on ball; free movement all other times

May labor in tub / shower

No IV / hep-lock

Free use of food & water

Limited cervical checks

Natural water rupture

2nd Stage

Reminder to empty bladder before pushing

Quiet! No directed pushing / counting

No episiotomy

Warm compress when pushing (if not a waterbirth)

Reminder to slow down when crowning

3rd Stage

Immediate skin-to-skin & breastfeeding ASAP

Delayed cord clamping; wait until pulsing stops; dad cuts

No controlled cord traction; physiologic birth of placenta

Only in case of PP hemorrhage (not automatically, after cord is cut); IM Pit

Newborn Care (in L&D)

Exams, prints, etc. on mom's chest; weight taken after golden hour

Yes – Vitamin K

No eye ointment

No Hep B

No bath

Newborn Care (in Postpartum)

Admissions, exams, etc. done in room with parent

No formula

No sugar water

No pacifiers

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Origin of the Birth Plan

Created 1970's

1980's

- World Health Organization
- avoid interventions and increase autonomy

Childbirth classes

- marketing tools
- medicalized

1990's- Early 2000's

- institutional tools of indoctrination or rebellion
- focus on medical interventions
- suppress communication
- provoke mistrust between patients and caregivers
- not significantly related to the level of participation in decision-making
- no differences in anxiety, pain, or general experience or sense of control
- patients perceived choices as illusory and largely superficial
- reported a fourfold increase in the risk of operative delivery



Origin of the Birth Plan

Did not improve relationships or communication

patients feel the plans were dismissed or disregarded

providers perceive pressure to perform and constriction of practice

younger and less experienced providers had a more negative view

irritate and alienate staff

increase obstetric interventions

Birth plan tension

reflects broader issues in prenatal care-

conflicting beliefs about birth, perceptions of safety and effective care, informed consent and informed refusal

PLAN OR MANIFESTO

2015 and beyond:
Birth plans are
associated with
improved
maternal and
neonatal
outcomes

higher rates of vaginal birth

shorter labor lengths

lower rates of pitocin use

lower rates of amniotomy

lower rates of epidural anesthesia

higher rates of immediate skin to skin

higher rates of breastfeeding initiation

lower NICU admissions

higher Apgar scores

Birth Trauma and PTSD – Can the Birth Plan prevent them?

Birth trauma

- related to the perceived or actual interpersonal behavior of health care team

Ineffective, authoritarian, paternalistic communication

- did not develop confidence, set goals, or make choices

- feelings of being undervalued and unsupported

- lack of conversation about birth plans– created a sense of dismissal and disempowerment

- less satisfied with provider's listening, support, guidance, and respect after birth with a birth plan

Trust and Psychological Safety

- priorities that have not been specifically addressed in written birth plans

- is the focus on core needs and preferences or on anxiety and hidden concerns?

If a patient does not trust medical staff, it is even more important for her to write a long and very detailed birth plan and then express concerns about it being adhered to.

Ok, which is it?

Are birth plans good or bad?

inconsistent

heterogenous

institutionalized

reflect medicalization of childbirth

specific focus on interventions

negative focus: what the patient wants to avoid

rigid

combative

false sense of control

set unrealistic expectations



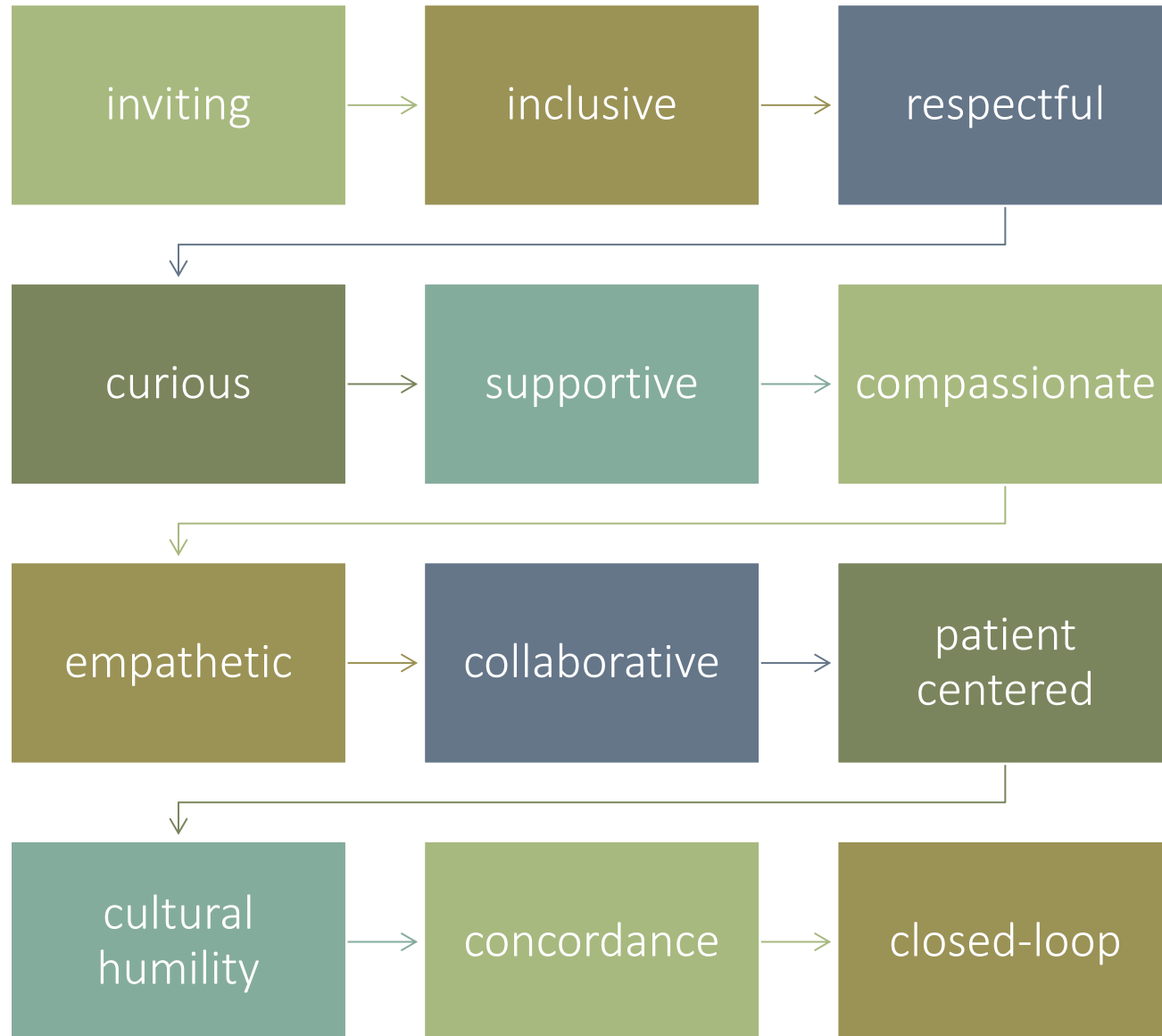
Well.....



Maybe



Birth Preference List: Decision Aid



Trust,
Psychological
and Physical
Safety with
Communication

Birth Preference Discussion

focus on
partnership

identify patient
goals and priorities

start at **28-32 weeks**

utilize anticipatory
guidance

quiet private
environment

trauma-informed:
addressing
psychological and
emotional needs

emphasize flexibility

standardized
preference
education

examine multiple
options/alternatives

utilize standardized
simple template

include postpartum
maternal and
newborn care

standardized SDM
Framework: BRAIN
or Three Talk Model
or SHARE

offer group
education

hire midwives

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, rebozos, combs, hot packs, counterpressure balls
- Intravenous lines, urinary catheters, enemas
- Pitocin 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
- Hydrotherapy
- Transcutaneous electrical nerve stimulation (TENS)
- Saline papules
- Pudendal, local, cervical block
- Open to options while in labor

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)
- 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
- Medication Management
- Use of vacuum or forceps in delivery

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

Applying SDM to Care Evaluation and Intervention or Plan Alteration

Patient's birth preferences and goals:

[e.g., desires minimal intervention, IV pain management, intermittent monitoring, non-lithotomy birthing position, free mobility]

Intrapartum events/deviations from plan:

[e.g., oxytocin augmentation initiated due to prolonged first stage, OR urgent cesarean recommended for Cat 2 tracing with recurrent deep early and late decelerations refractory to corrective measures]

Shared Decision-Making Discussion:

[specify intervention, e.g., IUPC placement / vacuum extraction / epidural / cesarean] thoroughly discussed with the patient and support person using BRAIN. Patient's understanding verified through ask-talk-ask; all questions answered. Patient's decision: [e.g., verbalizes understanding and elects to proceed / declines intervention]

Re-evaluation and continuous care plan:

Patient is comfortable with the modified plan, and the team will proceed and re-evaluate labor progress.

Barriers to Effective SDM

acuity

time constraints

staffing limitations

reimbursement
constraints

institutional policies

clinical workflow

inconsistent
preference list
template

Inconsistent
documentation

lack of standardized
decision-making
discussion process

litigious practice
culture

paternalistic
communication
style

authoritarian
communication
style

burnout

implicit bias

cultural bias

health disparities

systemic racism

general distrust of
medical community

limited health
knowledge

limited health
literacy

passive mindset

emotional stress

best practices for communication

effectiveness of varying decision aid formats

use of preference lists as decision aids in practice

birth preference SDM utilization in marginalized and vulnerable communities

evaluation of inclusivity and cultural appropriateness of decision aids

evaluation of risk perception and tolerance of the provider and patient

most effective application of the SDM process within the complex maternity-care environment

use of interdisciplinary team in SDM

Research Opportunities



Smart Phrases



Electronic Lists or Apps



Discussion Tools
Preference Lists

Documentation

Smart Phrases to the Rescue

Reviewed birth preference list. Discussed risks, benefits, and alternatives re: mode of birth, labor management, pain management, breast/chestfeeding, and newborn care. Patient provided with evidence-based decision aids and resources. Questions were addressed, and the patient's goals and personal values were incorporated into the plan of care. Decisions reviewed with patient. The patient verbalized understanding and agreement. Preference list to be scanned into chart.

Patient presented with a clinical decision **Induction of Labor in setting of A2DM**. Utilized the BRAIN tool to review options: *Benefits*: Reviewed advantages for patient and baby. *Risks*: Discussed potential risks, limitations, and side effects. *Alternatives*: Explored alternative management strategies. *Intuition*: Addressed patient's personal feelings and goals. *Nothing*: Discussed the potential outcome of expectant management. Questions addressed. Patient preferences and values align with the mutually agreed-upon decision – **IOL scheduled at 39w2d on 8/1/26 at 0900, her husband and mother will be available.**

Extensive shared decision-making discussion regarding TOLAC vs. elective repeat cesarean delivery (ERCD). Discussed the benefits of TOLAC (avoiding abdominal surgery, potential for vaginal birth) and the associated risks (uterine rupture approx. 0.3-1% depending on spontaneous labor v augmented labor, failed TOLAC leading to emergency C-section). Patient reviewed the Shared Decision-Making Toolkit for Mode of Birth After Cesarean. Discussed VBAC score: 72%. Patient's personal values and preferences understood. Informed consent obtained for TOLAC.

Documentation

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