Birth Plans: Encouraging Patient Engagement

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ABSTRACT

Patient engagement is defined as a set of actions by patients, family members, and health-care providers that promotes patients and family members as active participants of the health-care team. As focus turns toward patient engagement where patients have an active role in their health care, childbirth educators and nurses are in a position to support patient choices. The focus is to assist the engaged woman to stay engaged and to encourage those not engaged to become engaged. The results can be improved patient care outcomes and improved patient satisfaction. One way to promote patient engagement can be the birth plan. This process can be facilitated through education of choices and assisting with writing choices into a formal birth plan.

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INTRODUCTION

More than a decade ago, the Institute of Medicine began describing patient-centered care as a key component of quality care and specifically stated that patient preferences were to be considered in planning of care. Similarly, The Joint Commission National Patient Safety Goals and the World Health Organization World Alliance for Patient Safety point to patient participation in care as a means to improve the safety of that care (Holzmueller, Wu, & Pronovost, 2012). From these came the phrases “patient-centered care” and “person-centered care” which sees the patient or person as an active participant in his or her care or engaged in his or her care (Andrus, 2014; Barnes, Hancock, & Dainton, 2013). The end results of patient engagement can be improved patient care outcomes and improved patient satisfaction with care (Guglielmi et al., 2014).

Patient engagement can be defined as a set of actions by patients, family members, and health-care providers that promotes patients and family members as active participants of the health-care team (Pelletier & Stitchler, 2013). For childbirth educators, this definition is similar to family-centered nursing care in which the mother, her family, and the health-care provider are partners in decision making and care planning (Phillips, 1996). The idea of patient and family involvement in perinatal care is not a new idea. Olson in 1993 stated that family-centered care which is focused on the uniqueness of each

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mother and family is care that values and welcomes family involvement. She went on to say that “options are offered to the mother and family members, encouraging them to choose the level of participation they desire” (Olson, 1993). In 2005, the Institute for Healthcare Improvement described the ideal design for perinatal care. At the forefront of the design were the mother and family as the source of control by using patient preferences. The model went on to say that the tenets of care included “a prepared and activated mother and family,” additionally there should be “productive conversations between the mother, family, and the care team” (Institute for Healthcare Improvement, 2005).

Patient engagement is also getting more attention because of the Affordable Care Act and the linked financial incentives (Le, 2014; Sherman & Hilton, 2014). Likewise, the focus of the Meaningful Use goals fosters the connection of health-care providers and patients, in an active rather than passive role, together making decisions in health care (Byrne, 2014). In 2011, the Centers for Medicare & Medicaid Services (CMS) began paying incentives to hospitals and individual health-care providers that could prove that certain aspects of the electronic medical record were available to patients for their “meaningful use” (Ralston, Coleman, Reid, Handley, & Larson, 2010). With these payments came specific criteria and Meaningful Use goals of the certified electronic medical records. Open access to the patient’s own medical record is thought to increase both the safety and quality of care as they become actual contributors to their own care (Ahern, Woods, Lightowler, Finley, & Houston, 2011). Therefore, it is understandable why health professionals are interested in this topic.

Research indicates that patients who remain engaged in their own health care are more likely to remain healthy. The engaged patient is interested in his or her own medical conditions and stay abreast of information to improve their health (Robert Wood Johnson Foundation, 2014). Ultimately, the patient is the best source of information on his or her own conditions. The challenge for health-care professionals is to assist the engaged patient to stay engaged and to encourage those not engaged in their own care to become engaged (Schumann, 2013).

Compliance with a prescribed regimen of care is not the same thing as being engaged in care. Engagement implies action on the part of the patient, but to be able to take action, the patient must be knowledgeable of his or her role and choices. Patients must be empowered with education to be able to take action. Next, they must have the confidence and ability to be accountable for their own health choices. In other words, they must believe that they can be engaged (Longton, 2014; Pelletier & Stichler, 2014a).

When knowledge is shared with the patient and they are equal partners in the process, then power is shared. This sharing leads to engaging the patient and considering the patient’s preferences (Rulon, 2015). Both Barr (2013) and Evans (2013) propose that the use of a tool or decision aid to guide patients in decisions leads to a fuller understanding of patient choices and risks. This decision aid is the starting point for patient education and communication with the patient. One such decision aid of patient engagement for the pregnant patient can be the birth plan. A birth plan is used to invite participation in care and engage the woman in decision making about her care (Olson, 1993). One of the beginning steps of shared decision making in planning care is communication. Childbirth educators and nurses are in a prime position to provide interventions that enhance engagement while using the birth plan as a tool. Childbirth educators and nurses can educate about the process of labor, birth, evidence-based care, and choices in that care. Childbirth educators and nurses can also facilitate communication and negotiation with midwives and physicians as a patient advocate. Nurses can also create care plans based on the preferences of the patient by using the patient’s birth plan (Pelletier & Stichler, 2014b).

HISTORY OF BIRTH PLANS

The idea of the birth plan was first presented by Simkin and Reinke in 1980 as part of childbirth education class curriculum. It was born out of a generation where birth had become medicalized and choice for women had become very limited (Lothian, 2006; Simkin, 2007). Its introduction came at a time when perineal shaves and enemas were standard fare for women in labor (Carty & Tier, 1989). In its original form, it was to be a device for women to use as a springboard to launch conversations with health-care providers and to shed light on areas where choice of interventions in labor could be negotiated. The tone was to be polite and flexible, to apply to

simple and difficult labor, and would eventually be placed in the mother's chart so that all care providers were aware of the mother's desires (Simkin, 2007).

By the end of the 1980s, research into efficacy of interventions had begun in earnest. Practices that had once been standard, such as perineal shaves and enemas, fell out of routine for labor care. At the same time, other practices, such as induction of labor, began to grow (Cassidy, 2006). With these changes, women began to make requests and even demands of their health-care providers by way of their birth plans and wish lists (Carty & Tier, 1989).

RESEARCH FINDINGS RELATED TO BIRTH PLANS

In a study by Moore and Hopper (1995), 93% of the women participating reported that creating a birth plan improved their understanding of the process of labor and birth. In the same study, 92% believed that they were better able to express their wishes through the use of a birth plan. Of the study participants, 95% said that they would create a birth plan for a subsequent birth (Moore & Hopper, 1995). Brown and Lumley (1998) reported that two thirds of the participants in their study found creating a birth plan to be beneficial. Those reporting that it was not beneficial to create a birth plan cited the main disadvantage of birth plans was that health-care providers did not read them, were indifferent, or did not follow the mother's plan. In addition, the participants in this study were more likely to be satisfied with their method of pain control during labor (Brown & Lumley, 1998). Similarly, another study indicated that half of the participants reported that creating a birth plan did not change the outcome of their birth because the health-care providers did not attend to what they had requested. Even with this, 76% reported that they would create a birth plan in a subsequent birth (Whitford & Hillan, 1998).

In the last 10 years, much of the research has focused on outcomes and perceptions. In 2007, one study reported that participants with birth plans had similar rates of episiotomy and cesarean birth as those who did not create a birth plan but had lower rates of epidural anesthesia during labor (Deering, Zaret, McGaha, & Satin, 2007). Another study indicated that the majority of the participants believed that writing a birth plan enriched their birth event, heightened and illuminated their thoughts, and improved communication with their health-care provider. The majority of participants in this study were

pleased with their level of pain control during labor, even when they initially did not prefer to have anesthesia (Pennell, Salo-Coombs, Herring, Spielman, & Fecho, 2011). Yet, another research study looked at both maternal and neonatal outcomes. This study reported in 2013 implied that for nulliparous women with birth plans, there were improved neonatal outcomes as evidenced by better umbilical cord blood pH values than babies of nulliparous women who did not write birth plans. For all other women in this study, the reported outcomes were similar between the participants with and without written birth plan. Therefore, there is no harm to the mother and baby when birth plans are used, and there may be benefits for the babies of first-time mothers (Hidalgo-Lopezosa, Rodriguez-Borrego, & Muñoz-Villanueva, 2013). Finally, in a study published in 2014, women responded that they wanted their care provider to listen to women, provide encouragement, information, and offer choices for care (Nieuwenhuijze, Low, Korstjens, & Lagro-Janssen, 2014).

When looking only at the potential for fulfilling the components of a birth plan, it may be true that multiparas have the greatest chance to have their wishes fulfilled (Kringeland, Daltveit, & Møller, 2010). However, when all factors are considered, creating a birth plan is usually a positive experience for all women. The process leads women to have higher satisfaction with the birth experience, develop a greater sense of control, and achieve a more fulfilling birth event (Kuo et al., 2010). Perhaps it is the activation and engagement in their own care that leads to this rewarding birthing experience.

OPPOSITION TO BIRTH PLANS

In the nearly 35 years since the birth plan was introduced, health-care providers have had mixed feelings about the use of birth plans. Although some doctors, midwives, and nurses welcome the use of birth plans, many others do not (Wagner & Gunning, 2006). At times, health-care professionals believe that their education, knowledge, and opinions should be respected and they consider the use of a birth plan to be a challenge to their personal status (Kaufman, 2007). They perceive that the birth plan is a threat to their authority or knowledge, and so these patients can become the focus of jokes, condescension, and direct hostility (Simkin, 2007).

Some health-care professionals believe that the patient with a birth plan will have poorer obstetric outcomes such as a higher cesarean birth rate

than those patients who do not have birth plans (White-Corey, 2013). A study by Grant, Sueda, and Kaneshiro (2010) looked at this very issue and compared the perception of health-care providers with that of antenatal patients. Their findings were that 65% of medical professionals versus only 2.4% of antepartum patients believed that obstetrical outcomes were worse for those with birth plans. Likewise, 65.7% of health-care professionals believed that the rate of cesarean birth was higher in women with a birth plan, but only 8.7% of patients believed this to be true (Grant et al., 2010).

Still, other members of the health-care team, such as anesthesiologists, mistakenly believe that once the birth plan is created it must be followed completely. For example, for the patient who has requested no anesthesia during labor on a birth plan, some anesthesiologists will not administer this form of pain relief even when the patient requests such during the course of labor. Although the physician may be citing “following the patient’s plan” as his or her goal, the physician is in fact punishing the patient for creating the plan in the beginning. The physician is not following the tenets that the patient has the right to make an autonomous decision during the course of labor and that the patient has the right to pain control during labor (Walton, 2003).

Clearly the most opposition to birth plans comes from the ones that are not in line with the usual hospital or health-care provider’s routine (Bailey, Crane, & Nugent, 2008). What may not be clearly understood is the motivation of the patient to create these birth plans. One theory is that the patient is motivated by fear and lack of trust (Mulogo et al., 2006). Because the patient does not trust that the hospital, physician, midwife, or nurse will work with the mother to have an optimal experience fulfilled, the mother creates a document that she believes will lead to that fulfillment. The mother asks for much more than she hopes to receive, so that she will be happy with the portion that she can obtain (Lothian, 2006).

THEORETICAL BACKGROUND

There are several frameworks or theories that can be applied to the creation of birth plans. In their theory of collaboration, Wood and Gray (1991) define collaboration as occurring “when a group of autonomous stakeholders of a problem domain engage in an interactive process, using shared rules, norms, and structures, to act or decide on issues

related to that domain.” In the case of formulating a birth plan, the stakeholders are both the pregnant women and her family, along with the health-care providers—physician, midwife, childbirth educator, and/or nurse. The interactive process involves education of the benefits, risks, and alternatives of procedures and processes during labor. Generally with collaboration, there is implicit agreement to negotiate within defined norms. The action or decision is to agree on the aspects to be included in a birth plan, which is the domain (Wood & Gray, 1991).

The National Health Service Leadership Qualities Framework (United Kingdom) offers a hierarchy of collaboration. The first level is in essence no collaboration. It is called “goes it alone.” Next comes “appreciates others’ views.” This step acknowledges differing perspectives and outlooks. The next step is “works for shared understanding,” and it is at this stage the real work of collaboration takes place. The final step of collaboration is “forges partnerships for the long term.” This step ensures that plans for advancement develop longitudinally (Downe, Finlayson, & Fleming, 2010).

Anderson and Kilpatrick (2012) propose that there are two theories to use when addressing birth planning. One of these is the self-determination theory. In this theory, mothers are acknowledged as either engaged in planning care or passive depending on their social environment. It states that mothers are either extrinsically or intrinsically motivated toward action. Finally, it states that “competence, autonomy, and relatedness” are required psychological necessities related to the mother’s social environment. Anderson and Kilpatrick also propose the use of the theory of planned behavior. This theory states that a mother’s goals are predictors of her health-related behaviors, and if her goals are known, then her attitude about that health-related behaviors can be predicted (Anderson & Kilpatrick, 2012).

In her research on the formulation of birth plans, Doherty (2003) used Kim’s theory of collaborative decision making in nursing practice as her theoretical framework. Doherty states that the two main assumptions of Kim’s theory are as follows:

In nursing care situations many different types of nursing care decisions are made for clients that influence their health in a variety of ways; and clients have resources to be active participants in making such decisions and their participation may have effects on the outcomes of nursing care.

Doherty reports the results of her research imply that there are three different patterns of interactions when forming a birth plan. The first is called “pattern of directives” where no specific plan has been formulated but information and education is given by the health-care provider. The next pattern is called “pattern of emergence” where the mother has formed a birth plan but needs additional clarification to decide on those items of uncertainty. The final pattern is called the “pattern of validation” where the birth plan is complete, the mother can state her reasons for choosing each item, and the health-care provider is sought out to affirm that the choices can be honored. All of the patterns emphasize that the mother should remain flexible with her birth plan selections (Doherty, 2003).

IMPLICATIONS FOR CHILDBIRTH EDUCATORS AND NURSES

The childbirth educator is in a position to empower the patient and family with knowledge. Through education, the woman and family gains a clear understanding of the process of labor, develop confidence in their ability to birth, and learn decision making and negotiating skills. Gaining knowledge begins the process of activation and empowerment to become engaged in their own care (Lothian, 2006; Pelletier & Stitchler, 2014b).

Childbirth educators cannot make the assumption that just because a woman attends childbirth classes she is engaged in her care. Childbirth educators should presume that all class participants need information and the knowledge to make informed decisions (Longton, 2014). Not only should childbirth educators teach clients about birth plans, but they should also encourage the clients to create a birth plan while remaining flexible to changes and challenges that may arise. Perhaps class activities can focus on the wants and desires of the expectant family in creating a simple birth plan during class time. The template for the birth plan does not have to be elaborate. A simple format can be used, such as the one that follows:

1. These are the things I want for myself and/or my baby.
2. These are the things that I do not want for myself and/or my baby.
3. These are the things that I need to learn more about before I can decide whether I want this or not (Olson, 1993).

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The patient would then create a realistic birth plan prior to labor (Lothian, 2006).

In the ideal setting, patients would attend childbirth classes and learn the various options, risks, benefits, and alternatives to care during labor. However, in reality, only a small proportion of women are engaged enough in their care to attend childbirth classes (Smith & Waller-Wise, 2011). There needs to be a mechanism to begin to engage patients in their care decisions when they have not attended childbirth classes.

The nurse can use a birth plan as a decision tool to aid in engagement. By using a birth plan for every patient that presents in labor, nurses are engaging the patient on an individual basis to help promote optimal care and uncover and respect the choices for the birthing experience (Anderson & Kilpatrick, 2012; Philipsen & Haynes, 2005). The birth plan can be a springboard to discuss and gain knowledge about labor, birth, and choices. Birth plans simply handed to women to complete will result in little benefit. However, if given with a full explanation, encouragement, and activation, patient engagement can result (Olson, 1993).

Generally speaking, most nurses do ask patients for a birth plan of sorts, as questions are asked on admission to the hospital that is the beginning of a birth plan. Women are asked about newborn feeding preference, if they plan to have a son circumcised, or are planning for photographs to be made in the hospital, for example. Nurses could begin to incorporate many of the questions that are already asked on admission into a formalized birth plan. Even if women do not write a formal birth plan, they often do have preferences for how labor will transpire (Anderson & Kilpatrick, 2012). Documenting these in the form of a birth plan for all women could be beneficial.

A template could be used by either a childbirth educator or a nurse to simplify the process of creating a birth plan. The template could be as simple as the previously mentioned one proposed by Olson (1993). However, a much more specific one listing

TABLE 1
Example of Birth Plan

Attendants During Labor

- ☐ Partner/husband
- ☐ Doula
- ☐ Other _____

Attendants During Pushing/Birth

- ☐ Partner/husband
- ☐ Doula
- ☐ Other _____

Attendants During Cesarean

- ☐ Partner/husband
- ☐ Doula
- ☐ Other _____

Positions for Labor

- ☐ Walking
- ☐ Rocking chair
- ☐ Standing/swaying
- ☐ Squatting
- ☐ Side-lying
- ☐ Sitting
- ☐ No preference

Comfort Measures

- ☐ Birthing ball
- ☐ Massage
- ☐ Hydrotherapy
- ☐ Shower
- ☐ Music
- ☐ Aromatherapy
- ☐ Relaxation
- ☐ Acupressure
- ☐ No preference

Nutrition/Hydration

- ☐ Ice chips and popsicles
- ☐ Liquids
- ☐ Lollipops on stick
- ☐ Unlimited oral intake
- ☐ Running IV fluids
- ☐ IV lock
- ☐ Other _____

Medications

- ☐ Prefer to ask for medications
- ☐ Prefer to have medications offered

- ☐ IV medications
- ☐ Epidural
- ☐ Spinal
- ☐ Local for episiotomy
- ☐ Other _____

Positions for Birth/Pushing

- ☐ Sitting
- ☐ Squatting
- ☐ Side-lying
- ☐ Hands and knees
- ☐ No preference

The Birth

- ☐ Cord blood banking
- ☐ Delayed cord clamping
- ☐ Cord cut by _____
- ☐ No preference

Infant Feeding

- ☐ Breastfeeding
- ☐ Formula
- ☐ Pacifier
- ☐ No pacifier
- ☐ Nurse before first bath

Welcoming Baby

- ☐ Immediate contact with baby
- ☐ Dry baby first
- ☐ Delay prophylactic eye treatment and vitamin K (until after first feeding)
- ☐ Other _____

Baby's Health-Care Provider Will Be:

- ☐ _____

Postpartum

- ☐ Girl
  - ☐ Boy
  - ☐ Circumcision, if boy
  - ☐ No circumcision, if boy
  - ☐ Name _____
- (unofficial for nurses to call baby by name)

Additional Desires:

individualized preferences for interventions such as continuous or intermittent electronic fetal monitoring; intravenous fluids, an intravenous lock, or neither; or use of a shower or bathtub could be used. Not only would this be a means of engaging the patient, but it would also be evidence of an individualized nursing plan of care (Anderson & Kilpatrick, 2012). A generic format could be used for all women

(see Table 1), or women could be encouraged to develop their own format. Some hospitals have created their own template of birth plans that are available for use by women.

Childbirth educators and nurses should not deny or suppress knowledge that the family needs to have to make choice. Limiting the choices a woman is allowed does not foster full patient engagement and

may lead to disengagement. Likewise, childbirth educators and nurses need to support the choices that the woman and family make after receiving education even when those choices are not the choices that the childbirth educator or nurse would make for herself (Lothian, 2006).

Nurses need to review the birth plan with the patient and keep the plan readily available to refer to throughout the course of labor. The plan may need to be clarified and modified as new circumstances arise. Changes to the birth plan are often inevitable during the course of labor, especially if complications develop. Further engagement can occur with educating and asking the patient for permission prior to performing any new intervention. This review and modification process ensures full patient engagement during the process of labor. When possible, the plan needs to be revisited after birth to allow the patient and family time to reflect on how labor progressed (Anderson & Kilpatrick, 2012). This may foster the patient remaining empowered, activated, and engaged in their care after birth.

CONCLUSION

As the focus in health-care turns more toward patient engagement where patients have an active rather than passive role in their health-care, childbirth educators and nurses have a role to support client choices (Sherman & Hilton, 2014). The childbirth educator and nurse working together need to assist the engaged patient to stay engaged and to encourage those not engaged in their own care to become engaged (Schumann, 2013). The results can be improved patient care outcomes and improved patient satisfaction with the birthing experience (Guglielmi et al., 2014). One way to promote patient engagement can be the decision tool of the birth plan. A birth plan can be used to encourage participation in care and engage the mother and her family in decision making about her care (Olson, 1993). Childbirth educators and nurses can facilitate patient empowerment, activation, and engagement through education of the expectant family of the choices that are available and assisting the mother and her family to write their choices in a formal birth plan. This encourages full patient engagement throughout the hospital stay and beyond.

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