Birth Plans and Childbirth Education: What Are Provider Attitudes, Beliefs, and Practices?

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ABSTRACT

We describe the perception and practices of obstetric providers on birth plans and childbirth education (CBE) classes. Using a national online survey, we collected provider and patient demographics, practice settings, and perceptions. Of 567 surveys, 77% were physicians and 22% were midwives. This cohort believed prenatal care and CBE were predictors of patient satisfaction, while they had unfavorable views of birth plans. Most providers routinely recommended (69.7%) and had favorable views on CBE (84%). Most providers (66.5%) did not recommend birth plans and 31% felt they were predictors of poor obstetrical outcomes. Further research is needed to bridge the gap between provider beliefs and patient desires about their birth experience as well as to understand how to improve childbirth-related patient satisfaction.

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Childbirth education (CBE) classes are meant to prepare pregnant women and new parents for labor and childbirth (Ahlden, Ahlehagen, Dahlgren, & Josefsson, 2012). Both the American College of Obstetrics and Gynecology (ACOG) and the American Academy of Pediatrics (AAP) endorse attending CBE classes, many which include tenants for the preparation of a birth plan (AAP/ACOG, 2007; DeBaets, 2017; Soriano-Vidal, Vila-Candel, Soriano-Martin, Tejedor-Tornero, & Castro-Sanchez, 2018); however, the prevalence varies significantly.

CBE classes have existed since the 1960s (Koehn, 2002), while birth plans were introduced a decade later to serve as a communication tool between the mother and her obstetric providers (Epstein, Alper, & Quill, 2004; Lothian, 2006; Solnes Miltenburg et al., 2013). In the 1980s, in the midst of international criticism of an overly medicalized approach to pregnancy and childbirth, the World Health Organization (WHO) assigned CBE classes and birth plans to the top category of recommended practices for making pregnancy safer (WHO, 1996, 2006). While

the rate of attendance at CBE classes has declined over the years, birth plans have become an increasingly prevalent aspect of a woman's birth preparedness (Bailey, Crane, & Nugent, 2008).

Though the recommendation for CBE exists from ACOG and AAP, a 2007 Cochrane review suggested that there is no optimal method to meet the needs of expectant mothers, in spite of the array of methods in delivering CBE (Gagnon & Sandall, 2007). CBE has proven benefits, especially to adequately prepare first-time parents for childbirth (AAP/ACOG, 2007; Entsieh & Hallstrom, 2016). Results from a Mindfulness-Based Childbirth program demonstrate an increase in mindfulness and positive affect and decrease in depression and anxiety after attending CBE classes (Duncan & Bardacke, 2010).

Unlike CBE classes, the impact of birth plans on obstetric outcomes remains unclear. In a retrospective study of over 14,000 pregnancies, our group found that women who attended CBE classes and/or had a birth plan were more likely to have a vaginal birth (Afshar et al., 2017). However, in a recently completed prospective study at the same facility, we found no significant difference in the mode of birth for women with a birth plan compared to those without a birth plan (Afshar et al., 2018). Furthermore, despite receiving the care they preferred, women with birth plans described "not feeling in control" and were less satisfied with their birth experience than those women without birth plans (Mei, Afshar, Gregory, Kilpatrick, & Esakoff, 2016). In an attempt to understand why women with birth plans were less satisfied, we investigated how the number of items requested on a birth plan was associated with overall patient satisfaction. Specifically, plans with a higher number of requests were inversely associated with birth experience satisfaction, while having a higher percentage of requests fulfilled was positively associated with birth experience satisfaction (Mei et al., 2016).

Despite society endorsements for CBE, there has been a documented negative perception of birth plans by obstetricians and nursing staff (Grant, Sueda, & Kaneshiro, 2010). While CBE classes and birth plans are meant to facilitate patient-provider communication in childbirth, there appear to be large disparities in viewpoints between health-care professionals and patients on the obstetric outcomes of women with birth plans (Aragon et al., 2013; Jones, Barik, Mangune, Jones, & Gregory, 1998; Lothian, 2006; Lundgren, Berg, & Lindmark, 2003; Perez & Capitulo, 2005; Whitford et al., 2014; Whitford &

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Hillan, 1998; Yam, Grossman, Goldman, & Garcia, 2007). From the patient's perspective, Lundgren et al. found that women using midwives who had used a birth plan were less satisfied with their midwives' listening, support, guidance, and respect than the women without a birth plan, suggesting that birth plans may create a barrier between midwife and patient (Lundgren et al., 2003).

To further understand how to improve childbirth-related patient satisfaction and where quality improvement measures can be taken to increase patient satisfaction with the birth experience, we administered a national anonymous online survey on provider perceptions of birth plans and CBE classes.

Our objectives were twofold: first, to understand provider perceptions on CBE classes and birth plans, and second, to evaluate provider perception of patient satisfaction with participation in CBE classes and/or development of birth plans. We believe by accomplishing this, we will be able to provide insight into how to improve shared decision making and overall patient satisfaction with birth experience.

METHODS

This study was approved by the Institutional Review Board at Cedars-Sinai Medical Center, Los Angeles, California (Pro00041702). The objective was to assess the attitudes, beliefs, and practices of obstetricians and obstetrical providers (family physicians and midwives) regarding CBE classes and birth plans. We developed and administered a 39-question survey (accessed at: goo.gl/Ns6Y9D) to e-mail listservs available from ACOG fellow chapters and Society for Maternal Fetal Medicine (SMFM) fellows that included board-eligible and board-certified obstetricians. Additionally, we reached out to family practice physicians, midwives with affiliations to a birth hospital, and to local chapters of the Association of Women's Health, Obstetric and Neonatal Nurses, and the American Academy of Family Physicians. We

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used publicly available lists of midwives with birth privileges as well as personal contacts, asking recipients to forward the message to colleagues.

These practitioners were included if they deliver and/or self-identify as primary providers of obstetrical services. All potential participants received an e-mail blast, Facebook message, and/or Twitter request between December 2015 and July 2016. The link included an invitation to participate in the study and a link to the online survey. No data was extracted about how the patient obtained the survey. Participants were eligible to complete the survey if they were currently providing prenatal care and delivering patients. Surveys were considered incomplete if the provider did not include their role in the obstetrics team (i.e., type of provider) or if they did not provide primary obstetrical services (meaning antepartum care and deliver).

Part one of the survey collected data on provider demographics and characteristics of providers' patient populations. In part two, participants rated statements about various attitudes, beliefs, and practices concerning CBE and birth plans. The questions assessed provider views on the importance and impact of CBE and birth plans on birth outcome and satisfaction. A Likert scale ranging from 1 (not important) to 5 (very important) was used to evaluate responses.

The surveys were conducted electronically, and data was directly imported in Microsoft Excel and then exported into SPSS version 21 (IBM SPSS Institute, Inc., Armonk, NY). Descriptive statistics, including analysis of variance (for parametric data), the nonparametric Kruskal–Wallis rank sum test (for highly skewed data), Chi-squared test (for count data), and Fisher's exact test (for sparse count data) were used to compare data across groups. Intercorrelations between variables were investigated by Spearman rank correlation. For all analyses, the level of statistical significance was set at $p < .05$.

RESULTS

Of the 567 eligible surveys received, 77.1% were physician providers. The majority of respondents were female (88.7%) and Caucasian (73.4%); 30.5% currently practice medicine in the Pacific Southwest region of the United States (Table 1).

When asked to describe their patient populations, this cohort of providers noted heterogeneity in patient insurance status (Table 2). Most patients (61%) had at least a high school degree (Table 2).

TABLE 1

Demographics of Survey Respondents

	Number (%)
Gender	
Female	503 (88.7)
Male	61 (11.3)
Age	4 (0.7)
<25 years	
26–35 years	214 (37.7)
36–45 years	202 (35.6)
46–55 years	78 (13.8)
56–65 years	43 (7.6)
>65 years	13 (2.3)
No response	13 (2.3)
Race	
Caucasian	416 (73.4)
African American	22 (3.9)
Asian	33 (0.8)
Hispanic	30 (5.3)
Middle Eastern	10 (1.8)
Southeast Asian	16 (2.8)
Native American	3 (0.5)
Multiracial	23 (4.1)
Other/No response	14 (2.5)
Level of training	
Attending physician	336 (59.3)
Fellow/Resident physician	101 (17.8)
Certified nurse midwife	23 (4.1)
Certified professional midwife	107 (18.9)
Geographic region of current practice	
Pacific Southwest	173 (30.5)
Pacific Northwest	71 (12.5)
Southwest	66 (11.6)
Southeast	78 (13.8)
Northeast	74 (13.1)
Mid-Atlantic	23 (4.1)
Great Lakes	47 (8.3)
Great Plains	24 (4.2)
Other/No response	11 (1.9)
Practice location	
Urban: inner city	169 (29.8)
Urban: non-urban city	168 (29.6)
Suburban	110 (19.4)
Mid-sized town	56 (9.9)
Rural	34 (6.0)
Other/No response	11 (1.9)
Frequency provider delivers own patients	
Always	49 (8.6)
Sometimes	102 (18.0)
If on call	165 (29.1)
More often than not	112 (19.8)
Never	74 (13.1)
Other/No response	65 (11.5)

There was a discrepancy in provider perceptions of CBE classes compared to birth plans, with a decidedly more favorable view of CBE classes. Specifically, this cohort believed prenatal care (mean $\pm$ standard deviation [SD], 4.4 ± 0.9) and CBE classes

TABLE 2

Characteristics of Patient Population as Reported by Providers

	Number (%)
PPO patients	
<5%	44 (7.8)
6%–24%	62 (10.9)
25%–49%	137 (24.2)
50%–74%	97 (17.7)
75%–99%	69 (12.2)
100%	11 (1.9)
Proportion of private insurance (HMO, ACA) patients	
<5%	39 (6.9)
6%–24%	63 (11.1)
25%–49%	158 (27.9)
50%–74%	6 (13.4)
75%–99%	25 (4.4)
100%	23 (4.1)
Proportion of Medicaid/Medicare patients	
<5%	35 (6.2)
6%–24%	74 (13.1)
25%–49%	141 (24.9)
50%–74%	107 (18.9)
75%–99%	67 (11.8)
100%	12 (2.1)
Proportion of uninsured patients	
<5%	153 (27.0)
6%–24%	78 (13.8)
25%–49%	58 (10.2)
50%–74%	22 (3.9)
75%–99%	8 (1.4)
100%	4 (0.7)
Level of education of majority of patients	
<12th grade	62 (10.9)
High school degree	169 (29.8)
College degree	157 (27.7)
Graduate/professional degree	20 (3.5)
Unknown	137 (24.2)

Note. PPO = Proportion of private insurance; HMO = Health Maintenance Organization; ACA = Affordable Care Act.

(3.6 ± 1.0) were predictors of patient satisfaction. Most providers (69.7%) routinely recommended CBE classes and 84% had favorable views of CBE classes (Table 3).

Respondents endorsed several other important predictors of patient satisfaction with birth experience, including the physician–patient relationship (4.6 ± 0.9), the nursing–patient relationship (4.7 ± 0.8), and patient anxiety (4.3 ± 0.9). They had neutral views on doulas (2.9 ± 1.2).

Ultimately, the purpose of birth preparedness, CBE classes, and birth plans is to promote communication and education for pregnant women and their partners for the childbirth experience

In contrast, 66% of providers did not recommend birth plans and 31% felt they lead to poor obstetrical outcomes. Only 26% of providers had favorable views of birth plans and similarly only 25% felt that birth plans lead to favorable patient experiences (Table 4). These views did not vary by years in practice. Interestingly, although providers believed patients should decide on when to have pain relief during labor (4.2 ± 1.2) and what method of pain relief is best for them (4.5 ± 0.9), they had neutral views on whether a birth plan should be used to ensure pain relief preferences are met (2.6 ± 1.3 ; Table 5).

With increasing age, providers were more likely to recommend attendance of CBE classes and birth plans ($p < .01$). Increasing provider age had a significant correlation with believing that prenatal care, CBE classes, birth plans, and doulas were important predictors of patient satisfaction ($p < .05$). They were also more likely to have favorable views on CBE classes and birth plans, and more likely to believe birth plans lead to favorable patient experiences and favorable obstetrical outcomes ($p < .01$).

Providers with more years in practice were also more likely to recommend attendance of CBE classes and preparation of a written birth plan ($p < .01$). They were more likely to believe that prenatal care and CBE classes ($p < .01$) were important predictors of patient satisfaction.

Increasing years in practice also correlated with more favorable views of CBE classes and birth plans, as well as having a higher percentage of patients with birth plans ($p < .01$). They were more likely to believe birth plans lead to favorable patient experiences (-0.163 , $p < .01$) and favorable obstetrical outcomes (-0.150 , $p = .001$).

Providers with higher obstetrical clinical volume were more likely to recommend birth plans (0.118 , $p = .009$) and have more patients with birth plans (0.105 , $p = .016$; Table 6).

DISCUSSION AND IMPLICATIONS FOR PRACTICE

This is a study that examines present-day attitudes, beliefs, and practices among U.S. birth providers about CBE classes and birth plans. We

TABLE 3
Provider Perceptions of Childbirth Education and Prenatal Care

	Number (%)	Mean $\pm$ SD
Recommend patients attend CBE classes		
Yes	395 (69.7)	
Only to first-time mothers	88 (15.5)	
No	44 (7.8)	
Other/No response	40 (7.1)	
Provider views on CBE classes		
Very favorable	256 (45.1)	
Favorable	223 (39.3)	
Neutral	70 (12.3)	
Unfavorable	7 (1.2)	
Very unfavorable	0 (0)	
Extent CBE is important predictor of patient satisfaction with birth experience		3.6 $\pm$ 1.0
<i>Scale: not important (1); very important (5)</i>		
Extent prenatal care is important predictor of patient satisfaction with birth experience		4.4 $\pm$ 0.9
Extent having a doula is important predictor of patient satisfaction with birth experience		2.9 $\pm$ 1.2
Extent physician–patient relationship is important predictor of patient satisfaction with birth experience		4.6 $\pm$ 0.9
Extent nursing–patient relationship is important predictor of patient satisfaction with birth experience		4.7 $\pm$ 0.8
Extent patient anxiety is important predictor of patient satisfaction with birth experience		4.3 $\pm$ 0.9

Note. CBE = childbirth education; *SD* = standard deviation.

found that providers recognized the impact of the childbirth preparedness. We demonstrate that obstetric providers view CBE classes as an important correlative to patient satisfaction but have an unfavorable view of birth plans and often consider them not essential to the patient's birth experience.

Our survey results uncover that there is a continued need to address the ongoing need for patient-centered care and further effort is required to reconcile gaps between patient and provider expectations of educational tools important for childbirth. However, this disconnect did not translate into clinical practice based on survey results. Few respondents reported routine recommendations for CBE and birth plans even if they felt that the practice was important. Lack of certainty about the absolute and relative risk to the intrapartum course was noted as a limiting factor to the recommendation. Good clinical practice demands a level of scientific certainty and considers risks and benefits when advising patients about recommendations.

Ultimately, the purpose of birth preparedness, CBE classes, and birth plans is to promote communication and education for pregnant women and their partners for the childbirth experience (Whitford et al., 2014). Seeing as responsiveness of the providers plays a key role in patient satisfaction, perhaps recapping the benefits of CBE and birth plans depends on ensuring flexible, supportive discussions during pregnancy (Doherty, 2003; Epstein et al., 2005). Some studies suggest that even when women's documented preferences are not fulfilled, they express satisfaction with using plans because they find the discussion of their options to be beneficial (Whitford & Hillan, 1998; Yam et al., 2007). Whitford et al. suggested that it is the supported opportunity to discuss options for labor, and not necessarily the written or verbalized birth plan itself, that may be more important (Whitford et al., 2014).

The limitations to our survey study include a low response rate relative to the number of birth providers in the United States; it may not be representative of all practicing U.S. birth providers and types. Strengths of our survey findings include the fact that providers from all U.S. regions were represented in the sample, and our large sample size of 567 respondents, which included both early and late career obstetricians, family physicians, and midwives. Selection bias may have influenced the

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TABLE 4

Provider Perceptions of Birth Plans

	Number (%)	Mean $\pm$ SD
Recommend patients prepare with a birth plan		
Yes	117 (20.6)	
If patient desires	11 (1.9)	
No	349 (61.6)	
Discourage birth plans	20 (3.5)	
Only to first-time mothers	5 (0.9)	
Other/No response	65 (11.5)	
Provider views on birth plans		
Very favorable	42 (7.4)	
Favorable	104 (18.3)	
Neutral	192 (33.9)	
Unfavorable	182 (32.1)	
Very unfavorable	38 (6.7)	
Birth plans lead to (blank) patient experiences		
Very favorable	13 (2.3)	
Favorable	127 (22.4)	
Neutral	160 (28.2)	
Unfavorable	231 (40.7)	
Very unfavorable	25 (4.4)	
Birth plans lead to (blank) obstetrical outcomes		
Very favorable	9 (1.6)	
Favorable	79 (13.9)	
Neutral	296 (52.2)	
Unfavorable	159 (28.0)	
Very unfavorable	14 (2.5)	
Extent having a birth plan is important predictor of patient satisfaction with birth experience		2.6 $\pm$ 1.1
Scale: not important (1); very important (5)		

Note. SD = standard deviation.

TABLE 5

Provider Perceptions of Patient Pain Relief Preferences

	Mean $\pm$ SD
Patients should decide when to have pain relief during labor because they know how much pain they can cope with Scale: not at all (1); absolutely (5)	4.2 $\pm$ 1.2
Patients should decide what method of pain relief is best for them during labor	4.5 $\pm$ 0.9
Patients should have a birth plan to ensure their preferences for pain relief are met	2.6 $\pm$ 1.3

Note. SD = standard deviation.

results if providers that were interested in CBE or birth plans were more likely to participate. If so, our results would likely overestimate both the importance obstetricians place on birth preparedness and

TABLE 6

Spearman Rank Correlations of Provider Perceptions on Preparation for Childbirth

	Increasing Age of Provider Spearman Rank (p-value)	Increasing Years in Practice Spearman Rank (p-value)
Recommendation that patients attend CBE classes	0.159 (0.000)	0.186 (0.000)
Recommendation that patients prepare a birth plan	0.174 (0.000)	0.211 (0.000)
Belief that prenatal care is an important predictor for patient satisfaction	0.111 (0.010)	0.147 (0.001)
Belief that CBE classes are an important predictor for patient satisfaction	0.190 (0.000)	0.214 (0.000)
Belief that birth plans are an important predictor for patient satisfaction	0.108 (0.012)	0.06 (0.173)
Belief that doulas are an important predictor for patient satisfaction	0.089 (0.037)	0.057 (0.199)
Favorable view on CBE classes	0.154 (0.000)	0.167 (0.000)
Favorable view on birth plans	0.197 (0.000)	0.205 (0.000)
Having higher percentage of patients with a birth plan		0.137 (0.002)
Belief that birth plans lead to favorable patient experiences	0.166 (0.000)	0.163 (0.000)
Belief that birth plans lead to favorable obstetrical outcomes	0.149 (0.001)	0.150 (0.001)

how often they counsel their patients about the topic. Though the percentage of midwife providers that responded to our survey was on par to the percentage of-certified nurse-midwife-covered births in the United States (8.3%, according to the American College of Nurse Midwives) it would be worth looking at a larger sample of midwife attended births as their birth practices are often distinct and perceptions regarding CBE and birth plans may have been significantly different. However, we believe that this representation is more closely attuned to the provider population in the United States.

Today in the United States, birth plans are still the outliers, not the norm, for labor and birth. In Scotland, the use of birth plans is endorsed at the national

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level and standardized to a national maternity record, which to some extent has normalized its use (Whitford et al., 2014). Similarly, some institutions in the United States have also begun implementing such documents. This allows mothers to avoid relying on possibly inaccurate information and streamlines the birth plan creation process to maximize its potential as a tool for effective communication between providers and birthing mothers during the birthing process.

Considering these provider perceptions in our survey, and our previous studies on CBE and birth plans (Afshar et al., 2017, 2018; Mei et al., 2016), we propose that the physician or midwife help integrate the core concept of patient-centered care and shared decision-making. This integration will help patients make use of results of medical research to reach decisions that incorporate the best medical evidence with respect to patients' values and centers around flexibility to accommodate the patient's needs and desires. Epstein et al. have proposed a process that is informed by the needs and perspectives of the patient as well as by the physician's expertise for participatory decision making (Epstein et al., 2004, 2005). If the intention of the CBE classes and birth plans is birth preparedness and is to be shared with a provider, it should provide a stronger interaction between the patient and her providers (physicians and midwives; Kaufman, 2007), especially if she is unable to communicate effectively under certain circumstances (Perez & Capitulo, 2005; Perry, Quinn, & Nelson, 2001). If birth plans are viewed as a manifesto of personal preferences, under the notion of an *informed consent* of sorts, the birth plan should be used as part of the tenant of shared decision making.

Given that fulfillment of birth preferences appears to significantly affect patient experience and satisfaction, it may be useful to establish a universal approach toward creating and implementing birth plans to avoid these rifts. Rather than relying on possibly unreliable information collected from the Internet, streamlining the birth plan creation process could maximize its potential as a tool for effective communication between provider and patient during birth. The approach of a universal birth preference document acknowledges birth plans as flexible documents.

Birth cannot be planned, but preferences can be shared, and the provider must ensure that all parties are adaptive and flexible given the unpredictable nature of childbirth. Cook and Loomis (2012) found that when changes to a birth plan occurred, the amount of control the mother had over the changes mattered just as much as the degree of change itself. Thus, implementation of CBE and birth plans should not only take into account the unpredictable and dynamic process of labor, but also ensure continuous negotiations and communication among all participants involved (Cook & Loomis, 2012). Communication during the birthing process should acknowledge birth plans as flexible documents "evolving" with the unpredictable nature of childbirth (Brown & Lumley, 1998). Our hope is that this survey study prompts further specific discussion and research to find solutions to better understand how to improve childbirth-related patient satisfaction and birth experience.

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REFERENCES

- American College of Obstetrics and Gynecology & American Academy of Pediatrics. (2007). *Guidelines for perinatal care*. Elk Grove, IL/Washington, DC: Author.
- Afshar, Y., Mei, J. Y., Gregory, K. D., Kilpatrick, S. J., & Esakoff, T. F. (2018). Birth plans-impact on mode of delivery, obstetrical interventions, and birth experience satisfaction: A prospective cohort study. *Birth*, 45(1), 43–49. doi:10.1111/birt.12320
- Afshar, Y., Wang, E. T., Mei, J., Esakoff, T. F., Pisarska, M. D., & Gregory, K. D. (2017). Childbirth education class and birth plans are associated with a vaginal delivery. *Birth*, 44(1), 29–34. doi:10.1111/birt.12263
- Ahlden, I., Ahlehagen, S., Dahlgren, L. O., & Josefsson, A. (2012). Parents' expectations about participating in antenatal parenthood education classes. *The Journal of Perinatal Education*, 21(1), 11–17. doi:10.1891/1058-1243.21.1.11
- Aragon, M., Chhoa, E., Dayan, R., Kluftringer, A., Lohn, Z., & Buhler, K. (2013). Perspectives of expectant women and health care providers on birth plans. *Journal of Obstetrics and Gynaecology Canada*, 35(11), 979–985. doi:10.1016/S1701-2163(15)30785-4
- Bailey, J. M., Crane, P., & Nugent, C. E. (2008). Childbirth education and birth plans. *Obstetrics & Gynecology Clinics of North America*, 35(3), 497–509. ix. doi:10.1016/j.ogc.2008.04.005

- Brown, S. J., & Lumley, J. (1998). Communication and decision-making in labour: Do birth plans make a difference? *Health Expectations*, 1(2), 106–116. doi:10.1046/j.1369-6513.1998.00023.x
- Cook, K., & Loomis, C. (2012). The impact of choice and control on women's childbirth experiences. *The Journal of Perinatal Education*, 21(3), 158–168. doi:10.1891/1058-1243.21.3.158
- DeBaets, A. M. (2017). From birth plan to birth partnership: Enhancing communication in childbirth. *American Journal of Obstetrics & Gynecology*, 216(1), 31.e1–31.e4. doi:10.1016/j.ajog.2016.09.087
- Doherty, M. (2003). Birth plan decision-making patterns of interaction. *International Journal of Childbirth Education*, 18(2), 27–33.
- Duncan, L. G., & Bardacke, N. (2010). Mindfulness-based childbirth and parenting education: Promoting family mindfulness during the perinatal period. *Journal of Child and Family Studies*, 19(2), 190–202. doi:10.1007/s10826-009-9313-7
- Entsieh, A. A., & Hallstrom, I. K. (2016). First-time parents' prenatal needs for early parenthood preparation—A systematic review and meta—synthesis of qualitative literature. *Midwifery*, 39, 1–11. doi:10.1016/j.midw.2016.04.006
- Epstein, R. M., Alper, B. S., & Quill, T. E. (2004). Communicating evidence for participatory decision making. *JAMA*, 291(19), 2359–2366. doi:10.1001/jama.291.19.2359
- Epstein, R. M., Franks, P., Fiscella, K., Shields, C. G., Meldrum, S. C., Kravitz, R. L., . . . Duberstein, P. R. (2005). Measuring patient-centered communication in patient-physician consultations: Theoretical and practical issues. *Social Science & Medicine*, 61(7), 1516–1528. doi:10.1016/j.socscimed.2005.02.001
- Gagnon, A. J., & Sandall, J. (2007). Individual or group antenatal education for childbirth or parenthood, or both. *Cochrane Database of Systematic Reviews*, (3), CD002869. doi:10.1002/14651858.CD002869.pub2
- Grant, R., Sueda, A., & Kaneshiro, B. (2010). Expert opinion vs. patient perception of obstetrical outcomes in laboring women with birth plans. *The Journal of Reproductive Medicine*, 55(1–2), 31–35.
- Jones, M. H., Barik, S., Mangune, H. H., Jones, P., & Gregory, S. J. (1998). Do birth plans adversely affect the outcome of labour? *British Journal of Midwifery*, 6(1), 38–41. doi:10.12968/bjom.1998.6.1.38
- Kaufman, T. (2007). Evolution of the birth plan. *The Journal of Perinatal Education*, 16(3), 47–52. doi:10.1624/105812407X217985
- Koehn, M. L. (2002). Childbirth education outcomes: An integrative review of the literature. *The Journal of Perinatal Education*, 11(3), 10–19. doi:10.1624/105812402X88795
- Lothian, J. (2006). Birth plans: The good, the bad, and the future. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 35(2), 295–303. doi:10.1111/j.1552-6909.2006.00042.x
- Lundgren, I., Berg, M., & Lindmark, G. (2003). Is the childbirth experience improved by a birth plan? *Journal of Midwifery & Women's Health*, 48(5), 322–328. doi:10.1016/S1526-9523(03)00278-2
- Mei, J. Y., Afshar, Y., Gregory, K. D., Kilpatrick, S. J., & Esakoff, T. F. (2016). Birth plans: What matters for birth experience satisfaction. *Birth*, 43(2), 144–150. doi:10.1111/birt.12226
- Perez, P. G., & Capitulo, K. L. (2005). Birth plans: Are they really necessary? Pro and con. *MCN: The American Journal of Maternal/Child Nursing*, 30(5), 288–289. doi:10.1097/00005721-200509000-00002
- Perry, C., Quinn, L., & Nelson, J. L. (2001). Birth plans and professional autonomy. *Hastings Centre Report*, 32(2), 12–13. doi:10.2307/3528517
- Solnes Miltenburg, A., Roggeveen, Y., van Elteren, M., Shields, L., Bunders, J., van Roosmalen, J., . . . Stekelburg, J. (2013). A protocol for a systematic review of birth preparedness and complication readiness programs. *Systematic Reviews*, 2, 11. doi:10.1186/2046-4053-2-11
- Soriano-Vidal, F. J., Vila-Candel, R., Soriano-Martin, P. J., Tejedor-Tornero, A., & Castro-Sanchez, E. (2018). The effect of prenatal education classes on the birth expectations of Spanish women. *Midwifery*, 60, 41–47. doi:10.1016/j.midw.2018.02.002
- Whitford, H. M., Entwistle, V. A., van Teijlingen, E., Aitchison, P. E., Davidson, T., Humphrey, T., . . . Tucker, J. S. (2014). Use of a birth plan within woman-held maternity records: A qualitative study with women and staff in northeast Scotland. *Birth*, 41(3), 283–289. doi:10.1111/birt.12109
- Whitford, H. M., & Hillan, E. M. (1998). Women's perceptions of birth plans. *Midwifery*, 14(4), 248–253. doi:10.1016/S0266-6138(98)90097-3
- World Health Organization. (1996). *Care in normal birth: A practical guide*. Geneva, Switzerland: Author.
- World Health Organization. (2006). *Standards for maternal and neonatal care*. Geneva, Switzerland: Author.
- Yam, E. A., Grossman, A. A., Goldman, L. A., & Garcia, S. G. (2007). Introducing birth plans in Mexico: An exploratory study in a hospital serving low-income Mexicans. *Birth*, 34(1), 42–48. doi:10.1111/j.1523-536X.2006.00124.x

DISCLOSURE

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