



Reframing the Birth Plan

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With each new team member arriving that morning, the handoff went the same: a young woman, Cora, with an uncomplicated first pregnancy is in labor. Her water broke last night. Then, accompanied by an eye roll, comes a warning: “She has a birth plan.”

The medical team had an instantaneous, unspoken assumption upon hearing those words that an adversarial relationship with the patient would eclipse this typically joyous occasion. Beyond exasperation, there was fear that our hands would be tied in spite of needed intervention, that there would be a poor outcome, birth trauma, blame, maybe even a lawsuit.

I asked for the chart and read silently. Leah, the senior resident, the nurse, and a nursing student gathered to read along over my shoulder. About halfway down the page, Leah drew our attention to a line the patient had written, saying,

“There it is—this is what the birth plans are always about.” She read aloud the patient’s words: “I’d like to do everything possible to avoid a C-section.”

Gently, I disagreed. “Actually, I think for most people, birth plans are more about this sentiment here.” At the top of the birth plan, before specific interventions were ever mentioned, I indicated a short paragraph. It outlined a simple request: at every stage, explain to me

and my husband what you are recommending and why, and respect our autonomy—let us be a part of the decision too.

Leah conceded, but wondered: “Don’t we do that anyway as family physicians? I counsel my patients before interventions in labor, and I see my faculty do the same; where is this distrust coming from? Don’t patients know we are here to help them?”

I would have asked the same questions before I had been pregnant my third year of residency. It was only once I became pregnant myself that I fully understood how anxiety-provoking the prospect of birth could be. The stakes change when there’s a little life inside of you that you would do anything to protect. You pause in the middle of the day to wonder if he’s still okay when it’s been a while since the last kick. You fear what might happen to you. Will an emergency threaten me? Who will care for us? Will they be kind? How can I trust they’ll do the right thing? Even as a doctor, who has agency, power, and understanding in the medical system and who delivers babies herself, I had these fears.

I reminded Leah that it isn’t necessarily about us. Medical misinformation and consequent distrust are rampant. Patients may recall being dismissed or disrespected in past experiences. Even if neither of these is true, being a patient comes with a

feeling of giving up control. Giving birth is often one of the most pivotal moments of a woman’s life; anxiety is understandable!

To mitigate that reality, we can start our conversations about the birth plan outside labor and delivery. We can explain calmly, without the pressure of pain, an imminent intervention, or the threat of emergency. I explained that I encourage my patients to bring their birth plans to me and usually dedicate a visit to talking about how their medical care is likely to fit with their priorities. I explain what my priorities are as a doctor. We discuss situations when we might need to deviate from her preferences and what practices are standard locally. Reflecting, Leah agreed; she too had had similar conversations during prenatal care. She felt them to be empowering for the patient and rewarding for her. Generally, they would both leave that conversation feeling heard, and more critically, aligned.

With this in mind, we went to meet Cora. Although we met her for the first time during her labor, the same spirit guided our conversation. We summarized her labor course thus far, and discussed our recommendations for her. We solicited her questions and concerns. We

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left feeling confident we were all on the same page.

Later, Cora's pushing efforts were compromised by intense pain. We took into account her top two priorities: to avoid C-section and an epidural. We discussed a pudendal block, which she agreed to. As she continued to push, her variable decelerations grew deeper and more worrisome with each contraction. We explained that we may need to intervene quickly to help her precious baby boy. We advised her we might not be able to honor some of her plans. She'd spoken her son's name over and over between contractions and pushes; we could feel how much she loved him already. We made clear how our deepening concern for him drove our recommendations. Far from adversarial, we were palpably on the same team.

Cora ultimately delivered with vacuum assistance, required an episiotomy and early cord clamping. These things, as well as the pudendal block she had received earlier, had all been blacklisted on her original birth plan. Leah and I wondered how Cora was feeling. After the commotion of the delivery had settled, the resident and I spoke with the new family once more about their birth experience. Cora understood the deviations from her birth plan, and ultimately didn't feel discouraged by them. She felt proud to be holding her beloved healthy baby, and relieved to have avoided surgery. Most importantly, she felt grateful that she and her partner had felt informed, involved, and respected at each step.

As we left the delivery room, Leah noted how this patient hadn't been

difficult at all, even though at the beginning of the shift many had assumed she would be. I told her, "Don't fear the birth plan; view it as an opportunity. Recognize the anxiety, challenge your assumptions, and bridge the gap of distrust and uncertainty with empathy, understanding, and open communication. You're a family doctor. This is what you do."

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