A birth plan should not be viewed as an advance directive but rather as a record of aspirations. Labor is a time of improvisation, and no one can foresee its course.

Many of my obstetrical colleagues groan when a patient presents a birth plan during prenatal care. I, however, see it as an opportunity to do what Frank Chervenak and Laurence McCullough have called “preventive ethics”—avoiding conflict later by addressing issues before problems arise.

Prenatal care is unique in medicine in that we spend so much time with generally healthy patients seeking to prevent medical complications that, if they arise at all, are likely to occur much later during labor. The same mindset that propels and justifies prenatal care should direct our response to birth plans: this is an opportunity to prevent problems and misunderstandings during labor. The fact that the patient has well-formed opinions about what kind of care she wishes to receive during labor means she is engaged and seeking to educate herself. In short, women presenting with birth plans are generally our most conscientious and informed patients.

My approach toward addressing birth plans involves the following strategies. The first is to review the birth plan and quickly categorize all of the requests into three classes: “of course,” “probably,” and “nonstarter.” I first affirm everything I can affirm unequivocally. “You don’t want a shave or enema? No problem, we don’t do those things here.” Identifying all common ground first makes the tougher negotiations easier.

Next, I address the “maybes.” If the patient doesn’t want an IV routinely, for example, I respond that this is fine with me provided she has no medical issues (such as hypertension or diabetes), her labor progresses normally, she is group B streptococcus negative at her 36-week culture, and she recognizes that all analgesia requires an IV site. I believe it is important when laying out conditions for a particular procedure that we avoid phrases such as, “I always do IVs on all my patients, because that’s just the way I practice.” If you believe every patient needs an IV in labor, then justify why to the patient. But try to keep ego and personal preconceptions out of the discussion.

The last items I deal with are the hard ones: the non-negotiables. I start this part of the discussion not by drawing red lines but by asking why they want, or refuse, a particular procedure. I remember a patient who wanted a VBAC; she came in with a birth plan refusing continuous monitoring. This was a nonstarter for me because, as we know, it is often the monitor that gives warning of impending uterine rupture.

However, instead of refusing, I asked her why she was requesting it. She responded that she wanted to be mobile during labor; she wanted to walk around. First, I told her that we had telemetry monitors that allowed her to be mobile. Next, I expressed why I thought the monitor added to safety in labor, specifically in her situation. (I think the evidence is much less compelling for continuous monitoring of all labors.) After our discussion, she crossed out her request and added that she wanted telemetry monitoring.

Asking patients about what is behind their requests that you cannot honor, and then listening to and discussing those concerns, can successfully address many of the tougher requests in a birth plan.

Lastly, I always tell my patients that my comfort zones may be different than the limits that my partners may have, so I cannot guarantee that the decisions made during prenatal care will all be carried out during labor. As circumstances change, so may our determinations of what is safe and appropriate.

As I wrote elsewhere,1 we must not think of birth plans like advance directives. Prenatal care and labor are too fluid to anticipate every eventuality, and women in labor must be allowed to change their minds away from choices made before labor. In addition, physicians cannot be held to commitments made before labor for similar reasons. Birth plans record aspiration—aspirations that must be respected, addressed, discussed, and reviewed. However, patients must also understand
that labor is a time of improvisation, and neither patient nor obstetrician or midwife can foresee the course of labor until it is over.

References:

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