**Beyond the Baseline of Healthy Mom, Healthy Baby: Examining a Collaborative Birth Plan that Supports Physiologic Birth**

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**Overview**

Despite the increasingly exorbitant amount of money spent on hospital birth (Rivelli, 2024), growing levels of medical intervention (Simpson, 2022), and a Cesarean section rate that is more than double than what the WHO recognizes ideal (WHO, 2021), the United States has a maternal mortality rate that is higher than much of the developed world (Johnson, 2024). The medicalization of birth has clearly not improved outcomes.

In response, a growing number of women are seeking to birth outside of the hospital (CDC, 2022). Whether choosing to deliver in their home or in a birth center, these individuals prefer out-of-hospital birth for a variety of reasons. However, the financial challenges of paying for out of hospital care, including a general lack of insurance coverage, puts it firmly out of reach for many (Law, 2022). For these women, pursuing a physiologic birth in the hospital setting may be their only viable option.

As defined by the International Childbirth Education Association (2015), physiologic birth is, “A birth where the baby is birthed vaginally following a labor which has not been modified by medical interventions” (p. 1). In examining this definition, it becomes immediately evident that despite the multitude of benefits attributed to physiologic birth (Romano & Lothian, 2008), it is not commonplace in the US. In fact, the rate of labor induction alone has tripled since record keeping began in 1989 (Simpson, 2022). For women who desire physiologic birth, preparation is key in avoiding the interventions that have become popular in the US maternity care archetype. This includes crafting a birth plan, communicating that plan to their providers and medical staff, preparing for their delivery, obtaining necessary labor support, and navigating the complexities of insurance coverage to pay for it all. The following pages will examine the biopsychosocial factors affecting birth outcomes, discuss a model interdisciplinary birth plan, and explore the ethical, legal, and policy-based factors that complicate the process.

**Biopsychosocial Perspective**

Physiologic birth is multifaceted and affected by biological, psychological, and social factors. Addressing all angles improves the chances of physiologic birth being effectively supported.

**Biological Factors**

Physiologic birth is first impacted by the individual health of the laboring patient (Supporting healthy and normal, 2013). The absence, or at least minimalization of, intervention implies the absence of complications that necessitate it. Ideally, expectant patients should be generally healthy, and those that have chronic illness will benefit from ensuring their conditions are well-managed prior to becoming pregnant. That said, complications of pregnancy are not limited to mothers with preexisting risk factors, and issues such as gestational diabetes strike even the healthiest individuals. In situations such as these, induction or augmentation of labor may be warranted. However, for individuals lacking clinical indication, avoiding both is most supportive of physiologic birth (Supporting healthy and normal, 2013).

 While some variables are out of our control, physical fitness is one that most individuals have at least some jurisdiction over. Being able to move comfortably in our bodies and having a reasonable level of cardiovascular endurance allows for one to move actively to encourage labor and sustain the work of pushing. Body mobility accommodates birthing positions such as upright positioning, and the birthing person should be given choice of pushing position (Supporting healthy and normal, 2013). The use of wireless and/or intermittent monitoring also assists in facilitating unincumbered movement.

Besides having a baseline of strength and endurance, access to nutrition supports the physical rigors of giving birth. In order to best support the body at work, the laboring person should have access to both hydration and energy-rich foods as they desire (Supporting healthy and normal, 2013).

**Psychological Factors**

Health is not limited to the physical body, and physical fitness alone will not carry a laboring person through the birthing process; mental and psychological well-being is crucial to physiologic birth. An individual who is educated on the birthing process will be both empowered to advocate for themself and be able to fully participate in shared decision-making (Supporting healthy and normal, 2013). Further, they will possess the confidence that their body is well-suited to the task.

 Creating an environment in which the laboring person feels comfortable is also important. This includes the hospital room itself, the staff, and any guests or support persons present. Birth is an exceedingly personal event, and many individuals are better able to relax when privacy is ensured (Supporting healthy and normal, 2013). Careful attention should also be paid to any cultural or religious considerations that are applicable (Support healthy and normal, 2013). These may include restricting male staff from the delivery room, maintaining quiet during the actual birth, or providing for personal modesty.

**Social Factors**

Despite evidence to the contrary, the narrative in the United States that medical intervention is the ‘safe’ option and that women who refuse it are ‘putting their experience over safety’ is perversive. Judgment regarding declining intervention, even when clinically unnecessary, is exceedingly common. Experience on the labor and delivery unit confirms the prevalence of ‘the birth plan curse,’ which is the belief that patients who present with a birth plan are more likely to need intervention, experience complications, or even require surgical delivery. Even among experienced nurses, the phrase, “Healthy mom, healthy baby,” is often cited as a goal instead of the bare minimum and used to justify common interventions and deviations from patient preferences (Labor and Delivery Nurses Rock, 2021). All laboring individuals deserve access to nurses and providers who are practiced in supporting it rather than viewing the pursuit of a physiologic birth and the possession of a birth plan as a “First class ticket to the OR” (Labor and Delivery Nurses Rock, 2020).

**Model Interdisciplinary Birth Plan**

When considering all the factors that contribute to physiologic birth, it becomes clear that a team is necessary to both provide the most comprehensive and effective care. Within the context of a hospital birth, a birth plan accommodates for the various roles of the individuals working within the hospital system, acknowledges and addresses common protocols and procedures, and helps to identity care preferences in case an unexpected event should arise.

Planning ahead for complications does not assume the birthing process or person is inherently flawed, but recognizes that even when they arise, there is room for patient autonomy.

Like traditional birth plans, the following plan outlines considerations during antepartum, intrapartum, and postpartum periods. Unlike traditional birth plans, this model includes not only birth preferences that support physiologic birth, but also includes questions for the birthing person to consider when planning their delivery and building their team. It further seeks to explore how the hospital environment may impact the biopsychosocial factors discussed previously and identify opportunities to utilize resources to their advantage. This list is not exhaustive but serves as a jumping-off point for discussion.

**Antepartum: Setting the Stage**

1. What are my goals for my pregnancy, labor, and birth (for this plan, physiologic birth is the assumed goal)? Do I have a specific setting in mind? Do I or my baby have health conditions that necessitate a higher level of care? Do I have preferences regarding pain management?

 2. If I desire an out-of-hospital birth, what options are available locally? Does my insurance cover birth centers or homebirth midwives? If so, does it specify what kind of midwifery support it includes (CNM versus CPM vs DE/traditional midwife)? If I don’t have insurance currently and file for pregnancy Medicaid, what are coverage options in my state?

Regardless of birth setting, does my insurance cover doulas, as they are shown to reduce the incidence of cesarean section, shorten length of labor, reduce maternal anxiety, and improve breastfeeding rates (Sobczak et al., 2023)?

 3. Who will my provider be? Questions to ask include: “Are you comfortable with supporting unmedicated birth?,” “Do you encourage 39-week elective inductions?,” “What does pushing look like with you?,” “What is your cesarean section rate?,” and “What are your standard labor orders?” Labor orders include specifics like eating and drinking in labor, external fetal monitoring (EFM), and intravenous access.

 4. Where will I deliver at? Do they offer wireless monitors to promote movement? Do they offer pain management options like hydrotherapy? Do they have peanut balls and other tools to facilitate positioning if I choose an epidural? Consider a hospital tour to get the best idea of what the setting and amenities are like. What is their visitor policies?

 5. What childbirth, new parent, and lactation classes are available?

 6. What support will I have? Do I have a partner who can support me and is prepared and willing to do so? Do I desire a doula?

 7. How do I feel about cervical checks during routine prenatal visits? Will the information received affect my plan of care?

 8. Am I comfortable waiting for spontaneous labor? Do I plan to avoid induction unless medically necessary?

**Early Labor**

 1. How do I feel about spending early/latent labor at home and emphasizing rest, hydration, and nutrition?

**Active Labor**

1. What can I do to create a soothing and homelike environment: lighting such as

electric candles and string lights, music, and simple décor changes like covering monitors may help mask the hospital setting.

2. Will I be able to move freely, utilizing wireless monitoring or intermittent auscultation?

 3. Can I eat and drink during labor?

 4. What pain management options are available, if I decide I need it? Would I prefer to try nitrous oxide, hydrotherapy, or even intravenous medication?

 5. Under what conditions is labor typically augmented? Would I be okay with artificial rupture of membranes or Pitocin, and under what circumstances?

 6. If a cesarean section becomes necessary, what variables are within my control?

Who can come with me? Is a family centered/gentle cesarean an option? Would I prefer to not have my arms be restrained, to utilize a clear drape, to have music in the operating room, and to still have skin-to-skin time immediately after delivery?

**Second Stage**

 1. Would I like to limit outside conversation and the number of people in the room?

 2. Would I prefer to push in different positions besides lithotomy?

3. Does my provider support spontaneous, open-glottis versus directed, vasovagal

pushing?

 4. Is perineal support and/or warm compresses available? Does my provider perform episiotomies outside out emergent situations?

 5. Is delayed cord clamping routine?

 6. Does the hospital staff encourage extended skin to skin, delayed newborn medications/exam/weight/etc?

**Postpartum**

 1. What is the required postpartum stay for me? For my baby? Would I prefer a 24-hour discharge (or sooner)?

 2. Does my chosen pediatrician have privileges at the hospital, or will my newborn be seen by a hospitalist? Is that important to me?

 3. Does my hospital support rooming in and minimizing separation?

 4. Is the facility certified Baby Friendly? Are lactation consultants readily available?

**Ethical and Legal Considerations**

 The birth plan outlined above relies upon the premise that not only are the providers and staff caring for the birthing person respectful of patient autonomy, but that facility policies support individual choice. It also represents a mostly best-case scenario in which pregnancy, labor, and delivery progresses in a progressively linear or otherwise physiologically normal manner.

 However, birth is seldom predictable, and when providers and/or staff perceive a threat to the dyad, deference to patient preferences may be tossed aside. Patient autonomy may be perceived as secondary, inconsequential, or even oppositional.

 Despite popular belief to the contrary, precedent has been established to support patient choice, even over expert (i.e. provider) advice. Per ACOG’s Committee Opinion Number 664, “Pregnancy is not an exception to the principle that a decisionally capable patient has the right to refuse treatment, even treatment needed to maintain life. Therefore, a decisionally capable pregnant woman’s decision to refuse recommended medical or surgical interventions should be respected” (2016, p.1). Providers should ensure informed consent and document patient education but avoid any kind of coercion in discussing plans of care.

**Policy Analysis**

 I have been pleasantly surprised by the policies and practices at my clinical site. It should be noted that the hospital site where I am completing clinical is limited to one practice, which includes both midwives and Ob-Gyns. There are both a midwife and Ob-Gyn on call at all times, and when patients are admitted for labor or induction, they are given the option of either type of provider. Having a single practice at the hospital seems to make standardizing policies easier, as nurses do not have to remember the preferences of multiple obstetric practices. At the hospital where I work as a nurse, for example, five different practices, made of both practitioner groups and solo obstetricians, have delivery privileges. None employ midwives. Although certain individual practitioners may be more supportive of physiologic birth than others, the overall environment feels more medically inclined. In a hospital where midwifery care is the default, however, support of physiologic birth feels ingrained in unit culture.

 The first major difference I observed at my clinical site is the relative rarity of 39-week elective inductions. Unless delivery is medically indicated, most patients either labor spontaneously or induced after 40 weeks. The providers do a great job educating patients on the risks and benefits of induction, evaluating Bishop’s score, and discussing favorability with patients.

Further, there are more options for induction methods at my clinical site. My own hospital discontinued Cervidil a few years ago, citing cost. A single administration of Cytotec (misoprostol) is approximately $0.25 per 25 mcg dose, while Cervidil costs approximately $476 per dose (Epocrates, 2024). Protocol at both hospitals is more restrictive for administering Cytotec than Cervidil, which means that patients who are in need of cervical ripening are less likely to get it when Cervidil isn’t available. Additionally, Foley and Cooks balloons are frequently utilized at my clinical site, often in combination with low-dose Pitocin. At my workplace, however, they are highly uncommon. The overall emphasis on pursuing vaginal birth as an important clinical goal is much greater at my clinical site. I’m uncertain as to the cesarean section rate at both hospitals, but my hypothesis is that they differ greatly.

The availability of wireless external fetal monitoring (EFM) technology in every room at my clinical site also distinguishes it. When continuous monitoring is warranted, having wireless EFM encourages movement and accommodates the use of alternate methods of pain relief, such as hydrotherapy.

Another difference I’ve observed at my clinical site involves third stage and immediate postpartum. A minimum of 2-minute delayed cord clamping is the standard there, and great effort is made to protect and maintain the ‘golden hour.’ Even in a situation where additional stimulation and monitoring was needed post-shoulder-dystocia at one of my deliveries, these tasks were completed while the newborn was on the chest to facilitate skin-to-skin. Suction bulbs are also rarely used, which aligns with the latest NRP recommendations (Neumann et al., 2014).

**Reflection and Future Practice**

My fifteen-plus-years of experience in the birth world have been a transformative journey, beginning with working as a labor and postpartum doula, to starting out as a floor nurse in a labor and delivery unit, to transitioning to the midwifery role. During that time, I have had the privilege of attending births in a variety of settings, from homebirth to birth center to hospital, and have myself experienced labor and delivery both in and out of the hospital.

 Prior to attending nursing school, I had comparatively ‘crunchy’ views on birth. I worked with CPMs outside of the hospital, advocating for birth choice and licensure for non-CNMs. I also had the opportunity to support a vaginal breech delivery with a physician who is popular for being unapologetically supportive of patient autonomy. When I returned to school and pursued my nursing degree, I promised myself that I would always advocate for my patients and not cave to the popular nursing culture that considers birth plans to be predictive of poor outcomes.

 That said, it is difficult to stand apart from your coworkers and in both practice and philosophy. It is even more difficult to stand by your convictions when you see obstetric complications and emergencies. Supporting a patient’s desire to decline intermittent IV access feels more difficult when you’ve been the one struggling to find a vein during a postpartum hemorrhage. Intermittent monitoring becomes a tenuous proposition when the ever-present threat of litigation relies on analysis of a nurse’s interpretation and responsiveness to the fetal tracing, despite evidence to the ineffectiveness of continuous monitoring in preventing poor outcomes (Alfirevic et al., 2017). Although I was recently voted by my unit as the ‘peanut ball queen’ and ‘most likely to deliver her patient on the toilet,’ I admit that my experiences have impacted my outlook.

 That said, this course, and this assignment in particular, has renewed my faith in physiologic birth as not only safe, but worth striving for. Physiologic birth is not just a philosophical ideal; it’s evidence based. I stand at the bedside with fresh confidence that the majority of the time, birth works. Further, birth isn’t just about the physical experience of bringing a baby into the world, nor is it merely a medical procedure. Birth is a defining experience, and one that most remember for the rest of their lives. As esteemed midwife Ina May Gaskin wrote:

Giving birth can be the most empowering experience of a lifetime- an initiation into a new dimension of mind-body awareness- or it can be disempowering, by removing from new mothers any sense of inner strength or capacity and leaving them convinced that their bodies were created by a malevolent nature to punish them in labor and birth. (2011, p.7)

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