

## Delivery preferences in birth plan



### What delivery preferences are meant to do

Delivery preferences in a birth plan describe how you hope labor, birth, and the first hours after delivery will unfold. They may cover the room environment, who is present, pain management, mobility, monitoring, pushing positions, cord clamping, skin-to-skin care, and newborn medications. The goal is not to predict every clinical scenario. Instead, a well-written plan gives the team a quick, respectful snapshot of your values and priorities.

This matters because labor units are busy, care teams change shifts, and urgent decisions can arise. A clear plan can help everyone understand whether you strongly prefer an unmedicated labor, would like early epidural analgesia, want minimal noise, or want a support person to speak for you if you are overwhelmed. It can also help prevent repeated questions when you are coping with contractions.

The most effective birth plans are short, medically realistic, and flexible. A one-page document is often easier for clinicians and nurses to use than a long checklist. Consider highlighting your top three priorities, such as mobility, nonpharmacologic coping strategies, or immediate skin-to-skin contact. Then add a sentence acknowledging that you understand recommendations may change if

maternal or fetal wellbeing requires a different approach.

## **Choosing the birth setting and support team**

Your preferences should begin with where and with whom you plan to give birth. Hospital labor and delivery units, birth centers, and planned home births differ in available anesthesia, surgical backup, neonatal support, and transfer logistics. Discuss the safest setting for your pregnancy with your obstetrician, midwife, or maternal-fetal medicine specialist, particularly if you have hypertension, diabetes, placenta concerns, prior uterine surgery, a multiple pregnancy, fetal growth concerns, or preterm labor risk.

Support people are also part of the plan. You may want a partner, doula, family member, or friend present. Clarify who should be in the room during cervical examinations, epidural placement, active pushing, or an unplanned operative birth. Some units limit the number of people in the room, and policies may differ for cesarean birth or neonatal resuscitation.

A useful support-team section might include:

Who should be present during labor and birth.

Who may receive medical updates if you are resting or overwhelmed.

Whether a doula or support person may assist with positioning, counterpressure, breathing, and comfort measures.

Whether visitors should wait until after the first feeding or bonding period.

Who should cut the cord, if clinically appropriate and allowed by the facility.

It is reasonable to ask your team how they handle privacy, consent, learners, and room access. If you prefer that students or observers not participate, document that respectfully and confirm how your facility manages teaching environments.

## **Room atmosphere and communication preferences**

The environment can influence how safe, calm, and supported you feel. Many people prefer dim lighting, a quiet room, limited staff traffic, music, aromatherapy if allowed, or minimal conversation during contractions. Others feel reassured by frequent explanations and a brighter, more clinical setting.

Neither approach is better; the right atmosphere is the one that helps you cope and understand what is happening.

Birth plans can also describe communication preferences. For example, you may want clinicians to explain procedures before touching you, ask permission before vaginal examinations when possible, and use clear language about risks and alternatives. This is especially important for people with prior birth trauma, sexual trauma, medical trauma, or anxiety around examinations. You do not need to disclose personal details unless you want to; a simple statement such as "Please explain each step before exams and procedures" can be enough.

Because labor can become intense, decide in advance how you want information delivered. Some people prefer direct medical detail, including fetal heart rate interpretation and cervical change. Others want only essential updates unless a decision is needed. If you want your partner or doula to help process information, include that. Informed consent during labor should involve explanation of the recommendation, expected benefits, material risks, alternatives, and what may happen if the intervention is deferred, whenever the situation allows.

### **Pain management and coping strategies**

Pain management preferences are among the most common reasons to write a birth plan. Options vary by facility and clinical situation, but they often include epidural analgesia, intravenous or intramuscular medications, nitrous oxide where available, local anesthesia for repair, hydrotherapy, sterile water injections, massage, breathing techniques, visualization, heat or cold packs, movement, and continuous labor support.

If you hope to avoid pharmacologic analgesia, state what support you would like before pain medication is offered. For instance, you might prefer encouragement, position changes, counterpressure, shower or tub use if permitted, and reminders to breathe through contractions. Some people find it discouraging if staff repeatedly offer medication; others feel reassured knowing it remains available. Be specific but flexible.

If you are open to epidural analgesia, you can still include preferences. You might want to know when anesthesia should be called, whether mobility is

possible after placement, how bladder management is handled, and whether lower-dose or patient-controlled options are available. Epidurals can provide strong pain relief but may require intravenous access, blood pressure monitoring, fetal monitoring, and temporary limitations in walking depending on hospital policy and motor strength.

It can help to write preferences in conditional language, such as: "I prefer nonpharmacologic coping strategies first, but I would like information about epidural analgesia if I request it or if labor becomes prolonged." This preserves autonomy while recognizing that labor pain, fatigue, induction, malposition, and medical interventions can change what feels best in the moment.

### **Mobility, monitoring, and labor progression**

Movement can support comfort and may help some people cope with labor. You can document preferences for walking, upright positions, using a birth ball, hands-and-knees positioning, side-lying rest, showering, or changing positions frequently. If you have continuous fetal monitoring, an epidural, ruptured membranes with risk factors, induction medications, or other medical concerns, mobility may be modified for safety.

Ask your care team whether intermittent auscultation, wireless monitoring, or mobility-compatible monitoring is appropriate for your pregnancy and facility. Low-risk labors may sometimes use intermittent fetal assessment, while higher-risk situations may require continuous electronic fetal monitoring. The plan should acknowledge that fetal heart rate concerns, heavy bleeding, abnormal vital signs, or medication use may change monitoring recommendations.

You may also want to include preferences about routine interventions. Examples include intravenous access, artificial rupture of membranes, oxytocin augmentation, frequency of cervical examinations, and membrane sweeping before labor. These are clinical decisions that depend on context, but your plan can state that you want explanations and time to ask questions when possible. If induction is planned, discuss cervical ripening methods, oxytocin, amniotomy, pain relief, and realistic timelines before admission.

### **Pushing, vaginal birth, and assisted delivery preferences**

For the second stage of labor, delivery preferences may include pushing positions, coached versus spontaneous pushing, mirror use, touching the baby's head as it crowns, and whether you want a support person or clinician to announce fetal sex if not already known. Common positions include semi-reclined, side-lying, squatting with support, hands-and-knees, kneeling, or using a squat bar. Availability depends on maternal stability, fetal monitoring, epidural effect, clinician access, and facility equipment.

You can also state preferences related to perineal support. Some people want warm compresses, controlled delivery of the head, or guidance to pant rather than push quickly at crowning. Episiotomy is no longer routine in many settings, but it may be recommended in selected circumstances, such as urgent need for delivery or specific operative vaginal delivery situations. Your preference might be: "I prefer to avoid episiotomy unless medically recommended, and I would like an explanation if time allows."

Assisted vaginal delivery with vacuum or forceps may be considered when birth is imminent but help is needed, such as prolonged second stage, maternal exhaustion, or concerning fetal status. If you have strong feelings about vacuum or forceps delivery, discuss them prenatally, because the safest option may depend on fetal station, position, gestational age, clinician skill, and urgency. Your plan can request that risks, benefits, and alternatives be reviewed whenever the situation is not emergent.

### **Cesarean birth preferences and unexpected changes**

Even if you are planning a vaginal birth, including cesarean birth preferences can be empowering. It does not make a cesarean more likely; it simply helps the team care for you if surgery becomes the safest path. Preferences may include having a support person present, clear explanations during the operation, nausea prevention, music if allowed, a lowered drape or mirror at delivery, delayed cord clamping if appropriate, and skin-to-skin in the operating room when maternal and newborn conditions allow.

If you have a planned cesarean birth, ask about anesthesia, fasting, preoperative medications, infection prevention, thromboembolism prevention, postpartum pain control, breastfeeding support, and recovery expectations. If you are planning a trial of labor after cesarean, review facility resources,

continuous monitoring recommendations, uterine rupture risk, and criteria for changing the plan.

Unplanned changes can feel emotionally difficult, especially when you have prepared carefully. Consider adding a statement such as: "If the plan needs to change, please explain what is happening, why it is recommended, and what choices remain available." This supports flexible birth preferences while recognizing that nonreassuring fetal status, severe hypertension, hemorrhage, infection, arrest of labor, placental problems, or other urgent issues may require rapid decisions.

### **Immediately after birth: cord, skin-to-skin, and newborn care**

The minutes after birth are full of clinical care and emotion, so documenting newborn care preferences is particularly helpful. Delayed cord clamping is commonly requested and may be offered when the baby and birthing parent are stable. Timing and feasibility can vary with prematurity, neonatal compromise, maternal bleeding, or operative circumstances, so ask your clinician how your facility approaches it.

Immediate skin-to-skin contact can support bonding, thermoregulation, and early feeding for many dyads. Your plan can state whether you want the baby placed on your chest right away, whether routine assessments can be performed there when safe, and who should hold the baby if you are unable. If the baby needs evaluation by the neonatal team, you can request updates and reunion as soon as clinically appropriate.

Newborn medications and procedures should be discussed before labor. Many facilities routinely provide vitamin K to reduce the risk of vitamin K deficiency bleeding and eye ointment to reduce risk of certain neonatal eye infections, according to local policy and public health requirements. You may also need to decide about hepatitis B vaccination timing, newborn screening, hearing screening, circumcision if applicable, and whether you want to see or take home the placenta where legally and medically permitted by the facility.

Feeding preferences belong in the plan as well. State whether you hope to breastfeed, chestfeed, pump, use donor milk, use formula, or combine methods. If you want lactation support early, say so. If supplementation becomes

medically recommended, ask how the team will explain indications and options while respecting your feeding goals.

### **How to write a plan your team can actually use**

A practical delivery preference document should be brief, organized, and easy to scan. Use headings such as "Support people," "Environment," "Pain relief," "Labor and pushing," "If cesarean is needed," and "Newborn care." Place your highest priorities near the top. Bring copies to a prenatal visit, hospital registration if applicable, and your birth admission.

Before finalizing the plan, review it with your clinician. Ask which preferences are routinely supported, which depend on staffing or equipment, and which might not be available at your chosen facility. For example, hydrotherapy, nitrous oxide, wireless fetal monitoring, doulas in the operating room, or placenta release may be subject to policy. Clarifying this beforehand can reduce disappointment and help you adapt.

Try to avoid language that sounds adversarial, such as "I do not consent to any interventions." A safer and more collaborative approach is: "Please discuss recommended interventions with me before proceeding unless there is an immediate emergency." This keeps the focus on communication and consent without preventing urgent care when seconds matter.

Finally, remember that a birth plan is not a performance measure. Needing an epidural, induction, assisted vaginal delivery, or cesarean birth does not mean you failed. A good plan protects what matters most to you while leaving room for medicine, safety, and the unpredictable nature of birth.