

Pushing for Empowerment: The Ethical Complications of Birth Plans

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Abstract

The birth plan has become an increasingly institutionalized tool of Western birth practices, used both in medicalized and midwifery settings. Limited empirical research has been done on the efficacy of birth plans in achieving a commonly-ascribed goal: empowering women in their birth experiences. Still, less work has been done on the ethical dimensions of birth plans. As such, this tool has become nearly ubiquitous in birthing practices, yet they warrant further reflection. In this paper, I articulate the ethical goals of writing birth plans. I frame the birth plan as a narrative project: one that women are encouraged to write out, after careful consideration, as a kind of story that articulates the values, experiences, and relationships that are most important to shaping their experience of a “good birth.” Given the importance of the birth experience for many women, birth plans are ethical projects that the attempt to reframe and improve the deeper political dimensions of birth and patient choice. Birth plans are meant to structure the experience, guide women’s understanding of the process, and foster important clinical relationships. In this way, they are similar to advance directives, which are written to shape successful end-of-life care. Yet, the success of birth plans as tool for this ethical work is questionable. This tool aiming at women’s empowerment and ethical self-reflection often sets women up for a kind of ethical injury, in the attempt to avoid unwanted physical harms of labor and delivery. Birth plans are not legally binding, despite how they are framed as pseudo-contracts. Instead of resisting the challenges of a medicalized birth and to be empowered agreements, birth plans often set women up to fail, often aiming at unreasonable expectations. In my argument, I ask to identify for whom the birth plan works, and in which ways the birth plan experience can be improved. Finally, I address how the failure to give birth plans uptake during emergencies often undermines the patient-physician relationship, working against the primary goal of empowerment.

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“Pushing for Empowerment: The Ethical Complications of Birth Plans”

“Despite it all, I had high hopes for how the birth of my son, at a major hospital in the medical mecca of Boston, would unfold. I purposefully chose a female obstetrician. Armed with a birth plan, the latest fad in obstetrical empowerment, I knew I would sail through labor wearing my favorite black spaghetti-strap nightgown—no johnnie for me! The lights would be dim, an epidural anesthetic juicing my spine only if absolutely necessary. I had written won my instructions for the nurses to read so that even if I was in too much pain to explain it to them myself, my plan would be clear.”¹

Introduction

Since the early 1980s, the birth plan has become an increasingly institutionalized tool of Western birth practices, equally at home in both medicalized and midwifery settings. Limited empirical research has been done on the efficacy of birth plans in achieving a commonly-ascribed goal: empowering women in their birth experiences.² Still, less work has been done on the broader ethical dimensions of birth plans. Thus, this tool has become nearly ubiquitous, yet they warrant further reflection. This tool aiming at women’s empowerment and ethical self-reflection often sets women up for a kind of ethical injury, in the attempt to avoid unwanted physical harms of labor and delivery.

In this paper, I articulate the ethical goals of writing birth plans. I frame the birth plan as a narrative project, which women are encouraged to write out, after careful consideration, as a kind of story that articulates the values, experiences, and relationships that are most important to shaping their experience of a “good birth.” Given the importance of the birth experience for many women, birth plans are ethical projects that attempt to reframe and improve the deeper political dimensions of birth and patient choice. Birth plans are meant to structure the experience, guide

¹ Tina Cassidy, *Birth: The Surprising History of How We Are Born* (New York, NY: Grove Press, 2006) 2–3, online, Internet, 10 Mar. 2019.

² Paul Burcher, a physician and bioethicist, describes the tensions between empirical and normative work of birth plans: “The Ulysses contract in obstetrics: a woman’s choices before and during labour” *Journal of Medical Ethics; London*. 39.1 (2013): 27.

women's understanding of the process, and foster important clinical relationships. In this way, they are similar to advance directives written to shape successful end-of-life care.

Yet, the success of birth plans as tool for this ethical work is questionable. Birth plans are not legally binding, despite how they are framed as pseudo-contracts. Instead of resisting the challenges of a medicalized birth and to be empowered agreements, birth plans often set women up to fail, often aiming at unreasonable expectations. In my argument, I ask to identify for whom the birth plan works, and in which ways the birth plan experience can be improved. Finally, I address how the failure to give birth plans uptake during emergencies often undermines the patient-physician relationship, working against the primary goal of empowerment.

In this paper, I articulate the moral goals of writing birth plans. I then ask whether birth plans make women's lives better or improve clinicians' experiences.

What is a 'Birth Plan'?

Most women who have given birth in the last two decades may likely be familiar with the birth plan as a possible tool for planning or imagining what kind of birth experience they may want.³ Today, they are described in most books marketed to women about planning for birth, such as the commonly read *What to Expect When You're Expecting*.⁴ Historically, the birth plan was first developed in the late 1970s, in large response to the women's health movement. The written birth plan become common in the 1980s, but its historical roots go further back.⁵ It comes out of

³ While I focus on pregnant women's experiences in this paper, it is important to note that partners, husbands, and family members may also partake in the writing of birth plans and/or be influenced by them. Given the limits of this paper, I will not always draw attention to these additional experiences directly, although that is not to dismiss their ethical importance.

⁴ Heidi Murkoff and Sharon Mazel, *What to Expect When You're Expecting, 4th Edition*, vols., 4th ed. (Workman Publishing Company, 2008).

⁵ Judith Lothian, "Birth Plans: The Good, the Bad, and the Future" *Journal of Obstetric, Gynecologic, & Neonatal Nursing*. 35.2 (2006): 295.

women's healthcare movement, trying to resist medicalized birth. In prior moments, women had sought better pain management. Following this success, women developed the birth plan into a wider tool, one aimed at giving greater planning ability around birth, and perhaps the secondary goal of greater control around birth.

Birth plans are typically written documents meant to express women's goals and expectations about their birthing experience. Birth plans are formatted in a variety of ways, from detailed personal narratives to a common "tick box" form provided by hospitals, to web pages downloads, to notes taken on a verbal conversation. Some are brief (less than one page) articulating main goals. Others work as narratives, with explanations about why a certain procedure is requested or refused. A quick internet search for "birth plans" will provide one with a vast range of posted examples of peoples' personal birth plans, shared both with clinicians and with the public. In addition, users often provide narratives about birth plans, such as explaining why they have added (or opted not to add) certain features to their plans.

The birth plan can cover a range of topics, from the clinical (e.g., whether the pregnant woman wants epidurals or episiotomies considered/offered, wishes about C-sections, the goal of a standing and mobility while in labor) to what might be called the experiential factors (e.g., what music to play in the room; who should be present at delivery). Birth plans may also cover postnatal care issues, e.g., circumcision, vitamin K drops, or PKU tests. Women are often counseled to prioritize their goals, and then to discuss the plan with their midwife or obstetrician. Print materials often emphasize that these are articulations of what the woman wants, but this is not a "prescription" or "set of orders" for the clinicians at delivery.

The successful rise in popularity of the birth plan developed from women's health movements, but also from successes in bioethics in changing clinical practices, especially around

end-of-life decision-making. Do Not Resuscitate (DNR) orders, living wills, and health care powers of attorney have been developed to articulating patients' values and preferences at the end of life. Here, the goal of achieving a "good death" means interrogating patients' wishes and needs, say, around use of CPR, breathing tubes, or medications. Much like the birth plan, DNRs articulate which clinical actions are to be allowed, but this is shaped by patients' themes of respect, control, and lessening anxiety when patients at the end of life and their families must engage with clinicians. In part, by articulating these values and goals in writing, the hope is patients can receive the kind of care they wish from clinicians, without emotions or clinical "emergencies" overriding in these important moments.

However, there are limits to this analogy of birth plans to end-of-life documentation. While these other end-of-life documents have legal or policy protections, there is no legal standing for birth plans. They are not legal documents, despite the similar attempts to seek control. Despite mirroring the legal or policy language, birth plans are instated (at best) a documentation meant to ease discussions between pregnant women and clinical staff and may often be part of patients' medical charts. While women's demands may be made such documentation, clinicians often resist birth plans, noting that such promises cannot be guaranteed. They do not override hospital policies, nor does the birth plan itself replace other documentation about the woman's consent (or refusal) to other procedures.

Birth Plans as a Response to Medicalization of Birth

As a tool, the birth plan was crafted in the momentum of the women's health movement as a resistant response to the medicalization of birth. The exact definition of medicalization is often contested, but it largely refers to the reshaping of non-medical problems and variation into medical problems. A second related problem is that this changes agency, allowing only clinicians the

epistemic voice and authority to speak on these matters. When thinking about the medicalization of birth, specifically, then the feminist criticism focuses largely on what are appropriate medical interventions, are they utilized in the proper frequency (e.g., the questioning of C-section rates in the United States), and whether women have a voice in their own birth experiences given the traditional medicalized script by which births typically take place.

In writing a birth plan, women are outlining a kind of clinical agency that they are seeking. As such, it is more than a list of acceptances and rejections of clinical tools. The birth plan creates an agent who is either embracing or rejecting a medicalized framework of birth. But as I outline in greater detail below, often the work of birth plans are dismissed. We might describe such moments as acts of what Allison Wolf describes as metaphysical violence in the clinic: moments where agency and identity are undermined or prevented, typically improving clinical authority over the moment at hand.⁶

The reflective criticism of medicalized birth is an ethical project to the degree in which it allows women to resist unnecessary or unwanted medicalized experiences. The birth plan was one small tool, working to empower women to craft the kind of identity she wants to have (or to avoid) as a woman giving birth. Rather than seeing birth as exclusively a medical challenge demanding medical responses and oversight, it centralizes the experience of birth within the woman's larger life and goals. Birth plans here help women to reflect on what kind of patient she wants to be; whether she even wants to become a patient in the clinical setting of a hospital; who can help her achieve these goals?

⁶ Allison B. Wolf, "Metaphysical Violence and Medicalized Childbirth." *International Journal of Applied Philosophy*. 27.1 (2013): 101–111.

Why Write a Birth Plan? What are Women's Goals?

Although there has been much written about the crafting of birth plans, there has been surprisingly little ethical analysis of them. The explicit goals of birth plans frequently overlap in the clinical and lay literatures on birth. Here, I want to lay a foundation for analyzing the ethical goals of writing a birth plan, which are about allowing women to reflect on what kind of birth experience they would like to have and what kind of relationship they are seeking with clinicians. In the next sections, I identify three frequent goals cited as to why women might craft a birth plan: education of the woman; facilitate communication; and allow greater control and empowerment.

Education

For many women, writing a birth plan allows them time to educate and reflect about what the birth experience might entail. She might learn about possible birthing situations and procedures, which is the goal of quality childbirth education. This work may be especially important for women in their first pregnancy, since both the bodily experiences and the clinical culture may be new to them. Part of what happens here, though, is the expansion of women's moral imagination about what they may want, as well as how and who to ask for support in seeking these goals. Without such preparations, women may not know when and whether to ask, say, for pain medications during labor. The drafting of a birth plan facilitates this, in that many systems ask women to reflect on what medical services they are seeking (or seeking to avoid). Thus, in the creation of the birth plan, women are educated about not just medical facts, but the important ethical work of reflection on one's personal values, which may require the *creation* of those values for moments she has not previously considered or experienced. Yet many women remain frustrated when this act of moral self-definition remains one-sided—that is, fails to achieve uptake from others.

Improving Relationships via Communication

Another common goal for birth plans, one which has important ethical importance, is the improvement of relationships in birth, both between the pregnant woman and clinicians, but also with the woman and her other (non-clinical) support team, such as partners, dials, or family members. Many women, following suggested procedures, develop their birth plan and review it with their midwives or obstetricians. The plan is negotiated, and at the end of the meeting, everyone agrees it is a workable plan. At its best, this is how the birth plan is meant to foster communication and a sense of trust between patients and clinicians. Copies of the birth plan are distributed, including placed within the medical charts, ensuring its availability on the day of delivery.

In these relationships, the birth plan lets the woman communicate her goals and values clearly and in advance of birth. Birth plans thus help her articulate how she wants to be treated herself, but also her requests and expectations of others. Thus, the important ethical work here is communication of values, but allows for a foundation for developing multiple trusting relationships.

The results of this ethical work here are mixed. If one searches online for birth plans, one will also find numerous accounts of plans that both worked to support these relationships, with as many reports of failures. When birth goes smoothly and without complications, it is quite easy to attend to the details of birth plans. But most women expect that the birth plan covers both the uncomplicated and the complicated birth experience. Part of the planning for the future is to plan for both easy and difficult moments, and how we shall respond to both.

Consider reasonable cases when problems arise during labor. In such situations, many women report that the birth plan is quickly tossed out the window. In these moments, women may

rightly ask if the carefully crafted plan ever had real clinical support, or if instead there was a shallow agreement by clinical staff, knowing that the plan was non-binding. For these women, they often report feeling betrayed when the plan is not followed, when they realize the control they sought is largely illusory. Unless the plan has been discussed as only best-case guidance, or that it is at most a flexible plan (more on this later), then women may feel the birth plan has created a false foundation for their trusting relationships with clinicians.

Interestingly, nurses often report feeling frustrated, if not resentful, of birth plans. Physicians expect nurses to explain to patients, to cajole them if necessary, why the birth plan can no longer be followed. At these same crisis moments, patients often expect nurses to serve as their advocates by reinforcing the plan. This places many nurses, who may already be overworked, as mediators in a rigged game. In addition, there are discussions (both by pregnant women and nurses) about how to write birth plans that nursing staff will take seriously. Often, these advocate for clear language, simple plans, and ones that understand medical realities. But disturbingly, some nurses (perhaps in attempts be darkly comedic) note that they find the experience of birth plans a waste of energy, if not damaging. For example, one nurse wrote on her experience, “Sad to say but every birth plan I ever saw was ridiculous! Not to mention it was always a curse that led to a c-section!”⁷ Certainly, this does not reflect all nurses and clinicians, but it does provide insight in that clinicians may not support this tool, without articulating this clearly to the women they work with.

Consider a different albeit common experience, which raises further problems for communication and trust in the patient/clinician relationship. After the negotiation and agreement

⁷ “Say What?! Nurses Weigh In on ‘Ridiculous’ Birth Plans” *Parenting*. , 6 Dec. 2012, online, Internet, 1 Jan. 2019. , Available: <https://www.parenting.com/blogs/project-pregnancy/melanie-parentingcom/birth-plan>.

about the birth plan, will the birth plan be helpful during the delivery process? There is no guarantee the birth plan will be reviewed by midwives, nurses, or obstetricians as a reminder of what the woman's birth goals and preferences might be. And, being human and busy, clinical staff might be understandably unfamiliar with the details that are so deeply important to the woman in labor. Much like other information available, it is often common that the medical chart is provided a cursory review, if at all. More challenging, there is no guarantee the midwife or obstetrician will be on call the night one goes into labor. The attending may never read your plan or may have little motivation to take your plan to heart. As such, they may never know your preferences, or had little to no engagement in the crafting of this plan for shared values.

If women struggle to hold onto their original plan—say, to avoid episiotomies—clinicians often play what I think of as the trump card in the deck: “You want the baby to be safe, don't you? You don't want to harm the baby, to risk the baby's death?” Continuing the metaphor, at this point, most women just fold. Despite the work to craft and articulate the ethical values important to the pregnant woman, such clinical comments are common and largely eradicate the work intended by birth plans. Rather than feeling supported, women here may feel ignored—or worse, attacked—by the clinical staff she's working with.

Control

Although the not always an explicit goal of birth plans, the writing of such a plan often is intended to give women a greater sense of control over her birth. More than just articulating important values, a plan brings order to a complicated and important experience. We develop plans to bring order to many aspects as of our lives, not just birth. One mother compared the experiences of planning for birth to that of planning one's wedding, and the dangers of not planning:

“The other is the problem of simply letting things happen without any planning. Would you simply “wing it” on your wedding day with no preparation? Not likely. Our wedding

day is no less important and equally as stressful as birth. Not to mention there are unpredictable events at nearly every wedding. Planning your wedding well in advance can ease some of the stress for a new couple, just as writing a birth plan can make a birth experience a bit easier for everyone.”⁸

It may be reasonable to say that planning reduces stress for the bride and her guests, as well as for the woman in labor and the clinicians involved. However, taking the comparison at face value, when I hire a wedding planner to help guide me through the chaos, I am in charge as the one hiring for this service. This is not the case with the birth plan. While women work with a physician, she may be reasonably understood to be doing much of the work. In addition, we rarely give women the option to “fire” a physician when she is in labor. She can make requests, but as noted above, a woman’s consent can be undermined easily if the baby.

There’s something curious here about comparing these two “important” days of a woman’s life. Rebecca Kukla discusses this comparison by articulating a damaging double-standard women face. On the one hand, Kukla writes, “When women were first encouraged to draw up birth plans in which they specified their preferences...the laudable idea was to help women become at least partial agents of their own births, rather than passively submitting to medical management. However, over time, formulating a birth plan has moved from an empowering option to a social duty.”⁹ On the one hand, the culture around birth plans has evolved to nearly require women to create such a plan: women who fail to draft a birth plan are criticized as being uninterested, disengaged mothers, failing to live up to the newly evolved ethical duties expected of pregnant

⁸ As quoted at: “Our Birth Plan” *The Journey: Before and After Childbirth.* , 26 Jul. 2010, online, Internet, 1 Jan. 2019. , Available: <https://happymommy85.wordpress.com/2010/07/26/our-birth-plan/> Original post no longer available.

⁹ Rebecca Kukla, “Measuring Mothering” *IJFAB: International Journal of Feminist Approaches to Bioethics.* 1.1 (2008): 74–75.

women as ethical patients. But on the other hand, we penalize or dismiss women who articulate unrealistic expectations or get medical facts incorrect.

Further, women are often left unclear as to whether the plan is “set in stone” or merely advisory. Women are typically counseled to remain open to change, even while trying to gain stability in writing birth plans. Nearly every guide to writing a birth plan informs women to remain “flexible” as complications may arise, despite best efforts to avoid them. Note here that birth plans do not allow space for a “Plan B” or backup plan. The focus is on the expected, perhaps idealized, birth experience, while addressing the likely questions and challenges this woman may face given her clinical particulars. It is unlikely that all deliveries will go according to plan, as happens in all of medicine. Rather than have multiple plans articulated, nearly every book and article encourage women to “remain flexible” in their expectations since birth “doesn’t always go according to plan.” While the exact language may vary, there is a consistent and perhaps reasonable warning here to women that birth plans may have limits. But what does “flexibility” mean here, especially if you are seeking means to resist the damages of a medicalized birth, to regain a sense of control over one’s birth experience?

In jettisoning the birth plan, the woman is immediately returned to a pre-plan state. Her needs are rendered irrelevant, inarticulate, and control is returned to clinical judgment. The call to “remain flexible” is not a tool of resistance, in that it asks the vulnerable patient to change, without any examination, critique, or change to the dominant system that generated the problem. This loophole to the birth plan is, rather, a strategy for returning the woman to the position she originally sought to avoid, returning her to the master narrative of “doctor knows best.”

The Question of Empowerment

At this point, it is important to address a major ethical question around the use of birth plans: do birth plans empower women in their birth experiences? Empowerment here is importantly different than clinical efficacy or patient autonomy, but the way this term is frequently used in birth warrants our attention to its use. Although a valiant aim, I am often uncertain what women, clinicians, and bioethicists mean by their use of the term. In the quote at the top of this article, Tina Cassidy uses the term. The initial read is positive and supportive. But one can re-read her words as ambiguous: is she as birthing mother being empowered, or is “obstetrical empowerment” somehow continuing to support the status quo of obstetrics?

As Iris Marion Young writes, on the difficulties of pinning down a definition: “Empowerment is like democracy: everyone is for it, but rarely do people mean the same thing by it.”¹⁰ The term “empowerment” is most frequently used within feminist literature, and other liberation struggles. Despite being frequently used within both the birth movement and clinical bioethics literature, there has been rather little that finalizes a definition of empowerment.¹¹ The remaining problems might also be how to identify whether we’ve achieved it, and perhaps—if it is being misused—what harm may result.

Carine Mardorossian describes her experience with developing a birth plan, which I think can serve as an exemplar of the experiences of many women:

“Like many other women of my generation, I thought that because I was an enlightened and educated person who had assimilated feminism’s lessons, I was somehow less likely to be affected by the structures of power that surrounded me. I believed that my enlightenment in fact allowed me some measure of distance and control vis-à-vis

¹⁰ Iris Marion Young, “Punishment, Treatment, Empowerment: Three Approaches to Policy for Pregnant Addicts” *Feminist Studies*. 20.1 (1994): 48.

¹¹ Virginia L. Warren, “From Autonomy to Empowerment: Health Care Ethics from a Feminist Perspective” in *Bioethics, Justice, and Health Care*. Ed. Wanda Teays and Laura M. Purdy, vols., 1st ed. (Wadsworth Publishing, 2000), 49–53.

potentially disempowering situations. I had knowingly chosen a more impersonal and clinical setting for delivery, and I was determined not to let the environment in which I was to give birth have any bearing on my relationship to the birthing experience or to my husband. Their script, I thought, would not affect ours.

Little did I know, however, how meaningless our script would become in the context of labor and hospital practices. It was not that the medical staff was unwilling to accommodate our wishes but that our wishes quickly sounded hollow and trivial in the institutionalized context of the hospital where only systematic procedures appear reasonable and acceptable.”¹²

Ultimately, part of empowerment in medicine is giving voice to patients to decide how they wish to be treated. Whether birth plans work towards empowering patients is not, then, obvious.

The bioethicist Mary Mahowald rightly distinguishes medicine as a profession from medicine as a business. While a business has as its primary goal generating profit, a profession is “an occupation through which individuals are equipped through their education and training to exercise specific power or expertise in behalf of those who lack such power and expertise. However, the goal or end of a profession is to empower the other...so that he or she no longer needs the services of the professional.”¹³ This may be an idealist goal, but there are realistic means to empower women towards these ends. It frequently is attempted with the language of patient autonomy, listening to the voice to patients in deciding best actions. But as addressed earlier, the writing of birth plans may be a false voice, one listened to only when birth proceeds without complications. The successful birth—one that goes according to plan—is not really an indication of the successful birth plan. It may be perhaps a matter of luck—there were no complications faced. Or, it is a symptom of the woman’s own privileged social position: she has the money, education, power, authority to demand that her wishes be followed, something often lacking for

¹² Carine M. Mardorossian, “Laboring Women, Coaching Men: Masculinity and Childbirth Education in the Contemporary United States” *Hypatia*. 18.3 (2003): 124.

¹³ Mary Briody Mahowald, *Bioethics and Women: Across the Life Span* (Oxford University Press, 2006) 27.

women of color. This sets women of color up for poorer health outcomes,¹⁴ as well as frequently seen as hostile (rather than empowered) when declining medical services.

My own personal experiences with birth plans is from a distance over the last few years, via six female friends who were pregnant, and my friendship and support to them provided in various ways through their birth experiences. These women were all white, college educated (many with advanced degrees). Most wrote birth plans as either preparatory work, or some with the stronger conviction that it was part of their feminist identity and necessary work. Their tendency to write a birth plan may not be surprising, since women who write birth plans are more likely to be older and college educated.¹⁵ But even for these women, the birth plan failed in that they were typically not followed for a number of reasons. Only one woman in this group told me that she was fine with it: for her, it was really not that important to have stuck to the plan. But for others, the plan was deeply important and the failure of the plan resonated into the failure to as a woman to deliver “properly.”¹⁶

Getting empowerment “right” here matters for future uses of the birth plan. Some have argued for the export of birth plans to empower women of color and women outside of the United States.¹⁷ Given that white, educated, and financially independent women frequently find birth

¹⁴ Nina Martin and Renee Montagne, “Black Mothers Keep Dying After Giving Birth. Shalon Irving’s Story Explains Why” *NPR.org*, n.d., online, Internet, 1 Jan. 2019., Available: <https://www.npr.org/2017/12/07/568948782/black-mothers-keep-dying-after-giving-birth-shalon-irvings-story-explains-why>.

¹⁵ Shad H. Deering et al., “Patients Presenting with Birth Plans in a Military Tertiary Care Hospital: A Descriptive Study of Plans and Outcomes” *Military Medicine*. 171.8 (2006): 778–780.

¹⁶ Allison B. Wolf, “Birth without Violence” *JanusHead*. 17.1 (2019).

¹⁷ Eileen A Yam et al., “Introducing Birth Plans in Mexico: An Exploratory Study in a Hospital Serving Low-Income Mexicans” *Birth*. 34.1 (2007): 42–48.

plans to be less than empowering, we might proceed with caution and skepticism about expanding this tool to women who begin their clinical relationships with even fewer privileges.

To empower women in birth is not necessarily the same act as removing power from clinicians or medicine as a profession. As Mahowald writes elsewhere, the power of the profession of medicine “is morally exercised when it reduces domination by empowering the individual or group it serves. To the extent that its use dismantles their power or increases their domination, it is immoral; to the extent that its use fails to improve the status of the client or patient, it is amoral. Professional power is thus morally exercised as *power for empowerment*; it fulfills its essential purpose only to the extent that its exercise enhances the lives of those on behalf of whom the profession is practiced.”¹⁸ So, challenging the ethics of birth plans is to call upon obstetrics to reflect on how it uses power, rather a request to limit its power to serve patients.

Virginia Warren has argued for distinguishing between patient autonomy and empowerment. Both support patient decision making. But as Warren rightly notes, the standard view of patient autonomy is an individualist activity. The autonomous decisions of one woman, such as those described in a birth plan, does little ethical work to improve the autonomy of the next woman. Women make autonomous decisions despite clinical power, not in collaboration with clinical power. Empowerment, though, provides ethical improvement across bonds of community. Empowerment is accomplished with the support of others, not individualistically. Empowerment focuses on the social and political context, including how ethical decisions are made from within relationships of power that reflexively shape those same ethical decisions.¹⁹

¹⁸ Mary Briody Mahowald, *Women and Children in Health Care: An Unequal Majority*, 1st ed. (Oxford University Press, USA, 1993) 258.

¹⁹ Warren, “From Autonomy to Empowerment: Health Care Ethics from a Feminist Perspective” 51.

Birth plans have clearly become a public tool, in that they are frequently utilized and openly discussed. But this is not the same kind of success as bringing women together. Birth plans are ultimately individualized projects. They are crafted by women without needing to work with other women. The success of one birth plan does little to improve the success for the next woman. In fact, the isolation here may allow women for whom the birth plan fails to feel even more alone, in that the failure was her own, caused by unique birth experiences or a flawed birth plan. Birth plans by themselves do no real work in critically reflecting on the causes of a medicalized experience or articulating how *women* are created as agents.

Instead, individual women write individual plans for how they hope to best navigate the medicalized system of birth. As Elizabeth Bogdan-Lovis argued, this failure to empower is actually a result of the success—and unintended side-effects—of liberal feminist strategies in medicine.²⁰ The focus on individualistic liberal reform to ensure patients' rights, such as the focus on end-of-life documentation—ultimately worked to separate women from other women, given that communal action and reflection was no longer supported.

²⁰ Elizabeth A Bogdan-Lovis, "Misreading the power structure: Liberal feminists' inability to influence childbirth" *Michigan Feminist Studies*. 11 (1996): 59–79.

Conclusion

In this paper, I have argued for a more expansive ethical analysis of the birth plan, opening up questions beyond empirical efficacy, clinical satisfaction, and the basic bioethics analysis via informed consent and patient autonomy. Birth plans are meant to be tools to improve women's experiences in medicalized birth systems.

If the paper begins by asking whether birth plans accomplish their ethical goals, the conclusion is less than clear. In many ways, birth plans do important ethical work by helping women to identify and reflect on the values that shape their ethical decisions and may encourage women to embrace childbirth education in a richer manner.

I have argued here that the birth plan often fails on its own articulated goals in the practice of bringing about a good birth. Rather than promoting better doctor-patient relationships and patient empowerment—women often feel these goals remain out of their reach. Effective in achieving some goals, these pseudo-contracts are meant to inform decisions before and during birth, but within a system of change and likely unforeseen variables and clinical realities. The birth plan obscures attention to questions of social structures and powers within birthing practices. By continuing to isolate women's reflection, these do little to improve large-scale critique or change of medicalized systems of birth. As such, an individual woman seeking a good birth is often left with no tools for defending herself, for criticizing or correcting the very problems she faces. In this way, the "good birth" sought in writing a birth plan sadly often remains a fiction.

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Barry DeCoster is an Assistant Professor of Bioethics, with a joint appointment in the Department of Humanities and Communication and the Department of Population Health Sciences at the Albany College of Pharmacy and Health Sciences (Albany, NY). Trained in philosophy, DeCoster is interested in bioethical and the philosophy of medicine (epistemology and metaphysics of the clinic). More specifically, his research has looked at gender and sexuality. His co-authored manuscript, "Clinical Relationships and Feminist Values: How OBOS Benefits Collaborative Relationships in Women's Health", links archival work in the writing of *Our Bodies, Ourselves* to specific structures of modern doctor-patient relationships (forthcoming, *Peitho*). Recently his research has focused on LGBTQ health and the complications of medicalization.