

# informed decision making



Royal College  
of Midwives

# Key messages

Individuals must be provided with the expert advice and support that they would like, in order to understand the care, treatment and support options available to them. Receiving this advice and support enables women to make informed decisions about their health.

This briefing provides guidance on how to facilitate the informed decision-making process in daily practice and understand the underpinning regulatory and legal principles.



# Briefing overview

Women value midwifery support when they make a range of decisions including antenatal screening, mode and/or place of birth, induction of labour, intrapartum coping strategies, and infant feeding. However, The Association for Improvements in the Maternity Services (AIMS) (2021) and recent maternity surveys (Birthrights, 2020; Care Quality Commission, (CQC) 2020; Patient Information Forum, 2021) report that appropriate support is not always provided. Women with multiple disadvantages report less positive maternity experiences and outcomes than women without multiple disadvantages (McLeish & Redshaw, 2019; Rayment-Jones et al, 2019).

Recent reports have highlighted the link between safety and a culture of maternity care that listens to and respects the preferences and decisions made by women and families (Birthrights, 2020; Ockenden, 2020; CQC, 2021).

**“...women with social risk factors are more likely to experience paternalistic care and highlighted the impact of health care professionals’ assumptions based on race, class, ability, age, and other sources of oppression.”**

(Rayment-Jones et al, 2019:466)



Midwives report challenges to providing effective support for informed decision making. This can be from perceived limitations on their professional autonomy (Jefford et al, 2018; Sonmezer, 2021) the surrounding birth culture and care environment (Steinhaur, 2015; Farnworth et al, 2021), insufficient time and resources (Ahmed et al, 2013; Sonmezer, 2017) and lacking necessary understanding of the evidence base and ability to discuss this with women (Farnworth et al, 2021; Henshall et al, 2016) and fear of reprisal or litigation (Feeley et al, 2019).

**“Voices and choices:  
In line with the  
Cumberlege review  
‘First do no harm’,  
maternity services  
must ensure that  
all women and  
their families have  
information and  
support that allows  
them to make choices  
about their care.”  
(CQC, 2021).**



## The legal position

Midwives have a professional duty to uphold the Nursing and Midwifery Council's (NMC) Code (NMC, 2018) and to practise within the law of the United Kingdom (UK) by upholding human rights in the care that they offer and provide (British Institute of Human Rights, 2016).

### The NMC requires that midwives:

**“1.5 respect and uphold people’s human rights”  
(NMC 2018:6).**

UK law is made up of statute and common law. Article 8 of the European Convention on Human Rights (1950) (incorporated into UK law through the Human Rights Act 1998) protects the right to respect for private and family life, including protection of a woman’s right to physical autonomy and integrity (Birthrights, 2017).

**“Everyone has the right to respect for his private and family life, his home and his correspondence” (Human Rights Act 1998: Article 8 1).**

Respect for private and family life is interpreted by the courts to include the right for women to be provided with sufficient, objective and unbiased information to be able to make an informed choice (Birthrights, 2017). This is highlighted in the landmark ruling in *Montgomery v Lanarkshire* (2015) where Montgomery raised concerns on her baby’s size and her ability to birth vaginally during her antenatal period. Montgomery had type 1 diabetes mellitus, was of small stature and felt that her baby was large. However, her obstetrician felt that disclosure of any increased risk would have made her opt for a caesarean, which she believed was not in her best interest. Montgomery gave birth vaginally but experienced a shoulder dystocia that resulted in her baby suffering cerebral palsy. The ruling states that women have a right to information about any material risk to make an autonomous decision about their birth. Montgomery stated that she would have chosen to birth via caesarean if she had known of the potential risk in advance.



**“...patients are now widely regarded as persons holding rights, rather than as the passive recipients of the care of the medical profession.”**

(Montgomery vs Lanarkshire, 2015 (75)).

The courts also interpreted the right to private and family life to mean that women have the right to physical autonomy and integrity (Birthrights, 2017). This means that they have the right to decline any care that has been offered and that no care should be provided without their consent. Under UK law a fetus does not have any legal rights and so women are able to make decisions regardless of the interest of the unborn child. The only exception is if a woman lacks mental capacity to decide.

**The court found that even when his or her own life depended on receiving medical treatment, an adult of sound mind was entitled to refuse it. While pregnancy increased the personal responsibilities of the mother it did not diminish her entitlement to decide whether or not to undergo medical treatment. An unborn child was not a separate person from its mother and its need for medical assistance did not prevail over her rights; nor was her right reduced or diminished merely because her decision to exercise it might appear morally repugnant**

(St George's Healthcare NHS Trust v S, 1998).

## The midwife's role

Midwives must provide women with the information and support that they need to make decisions about their care and must respect the decisions that women make. While the outcomes of some informed decisions will result in a woman giving or declining consent for care (such as induction of labour), in other situations a woman will be deciding which course of action she prefers (for example, how she feeds her baby).

The phrase 'shared decision making' is often used within healthcare guidance and publications (NMC, 2018; NHS England 2019; NICE, 2022). Use of the word 'shared' suggests that the midwife or health care professional is involved in the decision making along with the woman.

It is more accurate to understand that the health professional is involved in supporting the woman to make her own decision by providing her with the information and evidence she needs. When a woman has made her decision, if the midwife has practised according to the Code (NMC, 2018) they are not responsible for that decision.

**Midwives who give women the best available evidence about a recommended course of action and any reasonable alternatives, document their explanation and discussion and then support a women's informed decision to decline are upholding professional standards and their human rights obligations, and have nothing to fear from lawyers or regulators**

(Birthrights, 2018).



# Key recommendations

## How midwives can support women's informed decision making

- **Provide balanced, transparent and reliable information**
  - This can be verbal and/or written information
  - Signpost to appropriate local and national guidance and organisations
  - Refer to specialist colleagues if required
  - Avoid sharing your personal opinion
- **Ensure understanding**
  - Provide easy to read publications if required
  - Provide professional translation services for written and verbal information if required
- **Facilitate the decision-making process**
  - Encourage the woman to ask questions
  - Consider using a decision aid
  - Understand that in many situations decision making is an ongoing process
- **Be an advocate for women and families**
  - Support the woman as she makes her decision, including if you are not acting as the lead caregiver
- **Act on the decision**
  - Respect the woman's wishes
  - Do not provide any care without first receiving consent
  - Refer to colleagues if required, in order to provide personalised care

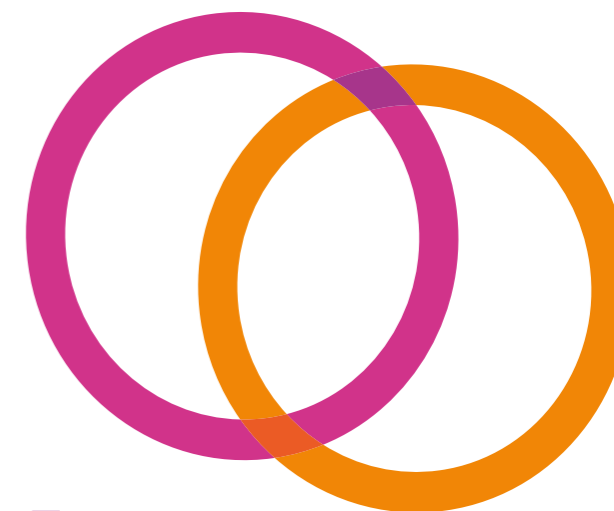


Signpost to appropriate local and national guidance and organisations

- **Record keeping**
  - Document the information you have given, the discussion you have had and the care you have provided
  - Share what is written with the woman

## How Trusts and Organisations can support women, parents and staff

- Review clinical guidelines to ensure that they promote women's autonomy in informed decision making
- Ensure that sufficient resources are available for staff and tailored to local population's needs
- Engage with advocacy services to provide training and awareness raising amongst staff
- Ensure interpreting, advocacy and translation services are readily available
- Introduce specific clinics (e.g. Multiple pregnancy clinic, VBAC clinic, Birth Reflection clinic)
- Develop continuity of carer to enable the development of positive, open relationships between caregivers and service users
- Engage with local Maternity Voices Partnerships
- Encourage staff to engage with their local RCM Learning Representative or their line manager or the Professional Midwifery Advocate (PMA) or Clinical Supervisor for Midwives (CSfM)



Engage with advocacy services to provide training and awareness raising amongst staff







## Conclusion

Understanding the way that UK law and the NMC Code require midwives to support decision making is fundamental to midwifery care. Information provision must be appropriate to the specific clinical situation to enable women to make an informed decision about their preferences and needs for care at each stage of their maternity experience. Women can make an autonomous decision to decline or consent to care, and this may include revisiting and changing their decision if they wish.

Midwives working in clinical practice must ensure that their individual approach to care provision aligns with the NMC Code. Guidance from the line manager, members of the multidisciplinary team or specialist midwifery services should be accessed when a woman's needs are outside the scope of a midwife's practice.

Maternity services must ensure that working practices and organisational culture, result in women being supported in their decision making. This must include specific consideration of the needs of marginalised women.

Midwives working in education, research and leadership roles must also uphold the NMC Code, ensuring that they too promote women's autonomous decision making within their role.

Support from a local RCM Learning Representative, line manager or PMA/CSfM can be accessed if a midwife feels uncertain about how to ensure that her practice aligns with the NMC Code.

**Midwives working in clinical practice must ensure that their individual approach to care provision aligns with the NMC Code**







## Useful resources

- AIMS website [www.aims.org.uk/](http://www.aims.org.uk/)
- Birthrights website [www.birthrights.org.uk/](http://www.birthrights.org.uk/)
- RCM Care outside guidance briefing (March 2022) Publications ([rcm.org.uk](http://rcm.org.uk))
- RCM Learning Reps Learning Representatives ([rcm.org.uk](http://rcm.org.uk))

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