

**DRAFT REVISION**  
**Midwives' Association of Washington State**  
**POSITION STATEMENT**  
**SHARED DECISION-MAKING**

**1. POSITION:**

It is the position of MAWS that licensed midwives have an ethical obligation to engage in a process of shared decision-making with the women in their care. The concept of shared decision-making differs from both the concept of informed consent and informed choice. Informed consent suggests a one-way flow of information and implies compliance with practitioner recommendations. Informed choice can convey the misleading sense that decisions are being made independent of any practitioner input. The term shared decision-making, however, captures the inherently relational quality of the exchange that ought to take place in discussions regarding all healthcare decisions.

**2. RATIONALE:**

Respecting a pregnant woman's right to bodily integrity and self-determination is one of the stated principles of every major midwifery and medical association involved in the provision of maternity care. Participatory decision-making is a widely held ethical ideal as well. Indeed, evidence strongly suggests that greater patient involvement in care results in better health outcomes and higher levels of patient satisfaction. Yet, pregnant women in the United States are finding their options increasingly circumscribed because of practitioner and institutional concerns about liability. How, in this highly charged medical-legal climate, should licensed midwives proceed?

A licensed midwife works in partnership with each woman she serves. Licensed midwives honor their clients as centrally important knowers, who bring to the decision-making process their own values, beliefs, intuition, experience, and knowledge. At the same time, licensed midwives have a responsibility to provide women with information on which to base decisions about their care. In this dialogue, licensed midwives draw upon the best available evidence and their professional expertise as well as their own values, beliefs, intuition, and experience. When the issue is a controversial one, midwives should invite their clients to participate in a process of critical inquiry in order to help them understand the political, social, and medical-legal context in which they are making their decisions.

Key to this discussion of shared decision-making is the concept of agency. Pregnant women have the right to determine their own relationship to risk. Likewise, licensed midwives have the right to determine their own professional boundaries, and they have an obligation to adhere to their scope of practice. What is an acceptable level of risk to one woman might be unacceptable to another, and providing individually responsive care is one of the hallmarks of midwifery. How, then can licensed midwives accommodate women who choose to conceptualize their relationship with risk differently than they do? How should the negotiation proceed if the woman is truly willing to accept the possibility of a less than optimal outcome? Where do the licensed midwife's own professional and personal limits enter into the negotiation?

In most cases, the interests of pregnant women and their babies converge rather than diverge. A midwife, therefore, ought to be able to honor the decision of a woman in her care as long as the following conditions are met:

- 2.1 The midwife and the mother have participated in a thorough process of shared decision-making
- 2.2 The decision does not require the midwife to break the law or to compromise her own personal or professional integrity, which would put her in a position of negligence
- 2.3 The mother is willing to accept full responsibility for the results of her decision

For further guidance on the process of shared decision-making, see appendix: NACPM Standards of Practice

**3. REFERENCES:**

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NACPM Standards of Practice, approved 2004  
MANA Statement of Values and Ethics, revised and approved October 1997  
ACNM Code of Ethics, approved June 2005  
ACOG Committee Opinion Number 390, December 2007 “Ethical Decision Making in Obstetrics and Gynecology”

**4. APPENDIX:**

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<http://www.nacpm.org/Resources/nacpm-essential-documents.pdf>

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