Supporting informed decisions

What informed decision-making means in birth care

Informed decision-making is a process in which a person receives relevant, understandable information and uses it to make a choice that fits their situation and values. In medicine, this process is closely related to informed consent and shared decision-making. The clinician contributes professional knowledge, including the evidence base, diagnostic findings, treatment options, and likely outcomes. The patient contributes knowledge of their priorities, concerns, lived experience, tolerance for uncertainty, and acceptable trade-offs.

The goal is not to identify one universally correct approach to birth. Different options may be reasonable for different pregnancies, and the balance of benefit and risk can change with gestational age, fetal position, maternal medical conditions, previous uterine surgery, placental location, labor progress, or signs of fetal or maternal compromise. A decision that was appropriate earlier in pregnancy may need to be reconsidered when new clinical information becomes available.

Evidence-informed care also requires attention to the quality and limits of evidence. The World Health Organization describes evidence-informed

decision-making as a structured process of finding, evaluating, and applying evidence alongside context and stakeholder perspectives. For an individual birth, this means asking not only what research shows, but also how the information applies to the specific clinical situation and what matters most to the person receiving care.

Clarifying values, priorities, and acceptable trade-offs

Before discussing individual procedures, it can help to identify the underlying priorities that may guide decisions. One person may place a high value on mobility during labor, another on early access to neuraxial analgesia, another on minimizing vaginal examinations, and another on having continuous fetal assessment because of a specific risk. Some people prioritize avoiding surgery when clinically reasonable, while others consider a planned cesarean birth the option that best fits their medical history and preferences.

Values are not fixed labels. A person may hope for physiologic labor while also wanting a clear plan for analgesia, or may prefer to avoid intervention but consider it acceptable if the expected benefit becomes substantial. Supporting informed decisions involves making these conditional preferences explicit rather than treating them as contradictions.

Useful questions include:

What outcomes matter most to me and my family?
Which experiences or interventions am I particularly concerned about?
What level of uncertainty feels acceptable?
What circumstances would make me reconsider my initial preference?
What information would help me feel prepared rather than pressured?

Discussing these questions during prenatal visits gives the clinical team time to explain relevant options and document important preferences. It also allows the person to revisit decisions as pregnancy progresses, without interpreting a change of plan as failure.

Comparing options, benefits, risks, and alternatives

Many birth decisions involve more than a simple choice between intervention and

no intervention. Options may include expectant management, additional monitoring, medication, a procedure, a change in birth setting, or a staged approach in which the situation is reassessed after further information is gathered. A balanced discussion should describe the expected benefits, common burdens, serious but less common complications, alternatives, and what may happen if no action is taken immediately.

Risk communication is most useful when it is specific and contextualized. Relative risk can sound dramatic without showing the baseline likelihood, while a single percentage may not explain how the outcome affects the individual. Ask clinicians to clarify the absolute risk where possible, the time frame involved, and whether the estimate applies to a population similar to the patient.

Questions that can improve clarity include:

What problem is this recommendation intended to address?
How likely is that problem in my current situation?
What are the potential benefits and downsides of each option?
Are there reasonable alternatives, including waiting and reassessing?
How urgent is the decision?
What signs would indicate that the plan needs to change?

Informed decision-making does not require certainty. Medical evidence may be limited, conflicting, or difficult to apply to an individual. Clinicians should acknowledge uncertainty rather than presenting estimates as guarantees. The patient can then weigh uncertainty alongside the consequences of each option and the practical realities of available care.

Using birth preferences as a flexible communication tool

A written birth preferences document can help communicate priorities to the maternity team, especially when several professionals may be involved. It might include preferred positions, coping strategies, support-person roles, pain-relief preferences, approaches to monitoring, communication needs, and immediate postpartum priorities. The document is most effective when it is concise, realistic, and framed around preferences rather than demands that cannot be guaranteed.

Birth preferences should be reviewed with the healthcare team before labor when possible. This discussion can identify which preferences are compatible with the planned setting and which may depend on clinical circumstances. For example, mobility may be affected by regional analgesia, intravenous therapy, or the need for continuous fetal heart rate assessment. Some monitoring approaches may be compatible with movement, but availability and suitability depend on the setting and the clinical indication.

A flexible document can use conditional language such as "I would prefer," "Please discuss with me before," and "If clinically necessary, explain the reason and alternatives." It may also include a section for situations requiring rapid change, such as operative birth, neonatal assessment, or transfer to a higher level of care. The purpose is not to dictate treatment in advance; it is to preserve communication and respect when decisions become time-sensitive.

Revising preferences during labor is also valid. Pain, fatigue, new findings, or a changed understanding of the options can influence choices. A person does not lose the right to ask questions or withdraw consent simply because a plan was discussed earlier.

Protecting consent and communication during labor

Labor can make it harder to process information. Contractions, fear, exhaustion, medication effects, language barriers, and a busy clinical environment may affect attention and recall. Clinicians can support comprehension by using plain language, explaining one decision at a time, checking understanding, and allowing pauses when the situation permits. A brief "teach-back" approach, in which the patient explains what they understand, can reveal confusion without testing or blaming them.

Consent should be an active process. Before an examination, medication, monitoring procedure, or intervention, the clinician should explain what is proposed and why, together with relevant risks and alternatives. In an emergency, the explanation may need to be concise, but the patient should still receive as much information and participation as the circumstances allow. Consent for one intervention does not automatically authorize unrelated

interventions.

A designated support person can help by asking for a pause, repeating a question, taking notes, or reminding the team of previously stated priorities. They should support the patient’s voice rather than replace it. If the patient cannot communicate or a true emergency prevents a full discussion, clinicians will act according to applicable law, professional standards, and the patient’s known wishes, while continuing to explain what is happening.

Respectful communication also includes acknowledging disagreement. A patient may request a second opinion, ask whether a recommendation is urgent, or decline an option after receiving information. Clinicians may explain when a requested intervention is unavailable, unsafe, or outside their professional responsibilities, and should offer appropriate alternatives or escalation pathways where possible.

Preparing for changing circumstances and urgent decisions

Preparation is most useful when it includes both a preferred pathway and contingency plans. Prenatal care may provide opportunities to discuss induction, pain management, vaginal birth after cesarean where relevant, operative birth, fetal monitoring, newborn care, and transfer arrangements. The appropriate topics depend on the individual’s history and local maternity services.

It is reasonable to ask how the team handles common changes in labor, such as slow cervical dilation, suspected fetal compromise, meconium-stained amniotic fluid, maternal fever, hypertensive disorders, or postpartum hemorrhage. These discussions should not be used to predict that a complication will occur. They help explain what assessments might be performed, who would be involved, and how recommendations could change.

Some situations require prompt or emergency assessment rather than extended deliberation. Severe or persistent abdominal pain, heavy vaginal bleeding, reduced or absent fetal movement after advice to monitor, fluid leakage with concerning features, severe headache or visual disturbance, chest pain, shortness of breath, seizure, fever, or feeling acutely unwell should be managed according to the maternity service’s urgent instructions. The

appropriate response depends on gestational age, symptoms, and individual risk factors, so contacting the responsible healthcare service is essential.

When time is limited, informed decision-making becomes proportionate rather than abandoned. The team can state the immediate concern, the recommended action, the main benefit, the most important risks, and the alternative of delaying. After the immediate situation is managed, clinicians should provide an opportunity to review what happened and answer questions.

Finding trustworthy information and support

Reliable information should be current, transparent about evidence quality, and relevant to the decision at hand. Professional guidelines, hospital or birth-center patient information, national health services, and peer-reviewed research are generally more useful than anonymous testimonials or content that presents one birth philosophy as universally correct. A source should distinguish established findings from expert opinion and should explain uncertainty.

People may encounter conflicting recommendations online. When this happens, bring the specific claim to a midwife, obstetrician, family physician, anesthesiologist, or other appropriate professional. Ask how the evidence applies to the pregnancy and care setting. A clinician who understands the patient’s history can also identify information that is technically accurate but not relevant to the current situation.

Practical support can include antenatal education, interpreter services, perinatal mental health support, social work, lactation support, physiotherapy, and patient advocates. These services do not replace clinical care, but they can improve access, comprehension, coping, and continuity. Support should be culturally responsive and accessible to people with disabilities, limited health literacy, different family structures, and varied financial or transportation circumstances.

Ultimately, supporting informed decisions means creating conditions in which the person can participate meaningfully: enough information to understand the choices, enough time to reflect when possible, honest discussion of uncertainty, and care that remains responsive as circumstances evolve.