

What's an Ethical Response to Home Birth?

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Frank Chervenak, MD, a maternal-fetal medicine specialist from Cornell, has published numerous articles in the last few years arguing that home birth is less safe than hospital birth and that the professional responsibility of physicians is to provide no support or participation in home birth.^{1,2} While his data has been contested by many, I would agree with Drs Ecker and Minkoff (of Harvard Medical School and Maimonides Medical Center) that the data are still inconclusive regarding the safety of home birth in America but that home birth in America probably incurs a small increase in absolute risk of poor outcomes for newborns delivered at home.^{3,4}

However, the data seem much more solid if instead we ask whether home birth *can* be safe. An observational study from The Netherlands that evaluated more than 500,000 births in homes and in hospitals showed no increase in adverse outcomes of any kind with home birth in low-risk women.⁵ So home birth, in ideal conditions where midwives and physicians work together as a team and where transport to hospitals in an emergency is highly efficient, appears as safe as hospital birth. Put another way, the data suggest that if home birth in America is more dangerous than hospital birth, it may be because of contingent factors that can be remedied.

While the distances in The Netherlands from home to hospital are obviously smaller than in many rural areas of this country, if obstetricians want a seat at the table to make recommendations regarding when women should travel to a hospital or birth center because of their remote home location, they are going to need to take a position that acknowledges home birth as a reasonable option that some women will choose. Similarly, physicians should oppose laws that make midwifery difficult to practice, or even illegal, in a home birth setting.⁶ Since obstetricians as a political lobby are largely responsible for these punitive laws, we should work to have them overturned if we seek to renew the trust of our midwife colleagues.

Professional Obligations?

What, then, are our professional obligations as obstetricians working in hospital settings to women who choose to stay home with a midwife for their birth? At the risk of sounding glib by answering a question with a question, do we enhance the safety of childbirth for all women by shunning home birth or by treating midwives collegially? I believe the correct answer is the latter, and since maternal-child safety was one of the founding reasons for ACOG's existence, I believe we have an ethical obligation at a minimum to accept transports from home with the respect and professional dialogue we afford our colleagues.

For some of us, the collaboration can include providing consultation and medical advice for home birth clients with medical issues that do not "risk them out" of home birth care. My argument for this is empirical if anecdotal.

I was a speaker recently at the Home Birth Summit in Seattle. Duncan Nielson, the chief of Women's Services for Legacy Hospitals in Portland, Oregon, described how by implementing a "home birth friendly" institutional culture, they saw a dramatic increase in transports to their hospital system from home birth midwives and that none of these transports were "train wrecks." That is, by being openly supportive and collegial, they had increased the interactions between the two models of care, and midwives brought in patients who were struggling at home sooner because they did not fear verbal reprisals or nuisance reports to the midwifery board by the physicians accepting care.

We saw a similar trend when we embraced a model of informal collaboration in Eugene, Oregon. We (myself and several of my OB partners) agreed to provide ultrasounds, prenatal consultations, and an occasional script for UTIs and other minor problems in home birth clients, and we encouraged our midwife colleagues to seek consultation early if medical complications arose either in labor or prior to labor. We did a number of medically indicated inductions on midwife patients with pre-eclampsia, gestational diabetes, or IUGR. By inviting the midwife into the hospital and encouraging their participation in the birth, even though we provided the management decisions during labor, we made women who desired home birth more comfortable with their now medically indicated hospital births.

While I realize this level of collaboration is beyond the comfort level of many physicians, I found it re-invigorated my own practice to sometimes share patients with home birth midwives. In turn, the midwives were much less likely to vilify hospital practices when they saw medical interventions used appropriately on their patients.

Home birth rates in America have risen significantly in the last few years. I believe this is driven both by a positive desire to give birth at home and by the negative associations that hospital birth has created, including the popular perception that we are doing too many unnecessary cesarean sections. While I agree with Dr Chervenak that we should make hospitals more accommodating to our patients, if we wish to make birth as safe as possible then shunning our home birth colleagues cannot possibly be the way to achieve greater safety for pregnant women and babies.

In contrast to Dr Chervenak's views, it is my assertion that our professional responsibility must include supporting all of the birth options women have and to make each as safe as possible. The Netherlands has shown that safety comparable to a hospital is achievable. We should strive to replicate their results.

References

1. Grünebaum A, McCullough LB, Sapra KJ, et al. Apgar score of 0 at 5 minutes and neonatal seizures or serious neurologic dysfunction in relation to birth setting. *Am J Obstet Gynecol*. 2013;209:323.e1-6. Available at: [http://www.ajog.org/article/S0002-9378\(13\)00641-8/pdf](http://www.ajog.org/article/S0002-9378(13)00641-8/pdf). Accessed December 1, 2014.
2. Chervenak FA, McCullough LB, Brent RL, et al. Planned home birth: the professional responsibility response. *Am J Obstet Gynecol*. 2013;208:31-38.
3. Minkoff H, Ecker J. A reconsideration of home birth in the United States. *J Clin Ethics*. 2013;24:207-214. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/24282848>. Accessed December 1, 2014.
4. Ecker J, Minkoff H. Home birth: what are physicians' ethical obligations when patient choices may carry increased risk? *Obstet Gynecol*. 2011;117:1179-1182. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/21508760>. Accessed December 1, 2014.
5. de Jonge A, Geerts C, van der Goes B, et al. Perinatal mortality and morbidity up to 28 days after birth among 743,070 low-risk planned home and hospital births: a cohort study based on three merged national perinatal databases. *BJOG*. Sept 10, 2014. doi: 10.1111/1471-0528.13084. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/25204886>. Accessed December 1, 2014.
6. Midwives Alliance North America. Legal status of U.S. midwives. Available at: <http://mana.org/about-midwives/legal-status-of-us-midwives>. Accessed December 1, 2014.

- See more at: <http://www.obgyn.net/pregnancy-and-birth/whats-ethical-response-home-birth?cid=jointheconversation&GUID=6AB23BA5-9473-40A4-AD08-8249040E3F6B&XGUID=&rememberme=1&ts=11122014#sthash.XYJMVGHM.dpuf>