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Why Home Births Are Worth Considering

A new analysis by Dr. Joseph Wax comparing home births and hospital births, which was published in the recent issue of the *American Journal of Obstetrics and Gynecology*, not only presents misleading conclusions, it drives a wedge between two groups that cannot afford a greater divide: medical doctors and midwives.

The study documents similar perinatal (or the period immediately surrounding birth) mortality rates for home and hospital births, but claims a three-fold increase in neonatal (measured up to 28 days after delivery) mortality for home deliveries. Yet this analysis contains serious limitations and concerns those of us who practice midwifery in an out-of-hospital setting.

Beyond the issue of the flawed methodology, which has been addressed by several national organizations, including the Coalition for Improving Maternity Services and the Midwives Alliance of North America, there are serious cultural implications to this study.

As a medical anthropologist, I am concerned with the chasm with doctors and the medical establishment on one side, and midwives and the home birth movement on the other. In Oregon, where we have both licensed and unlicensed midwives working in home and in birth center settings, research has shown deep mistrust between doctors and some midwives. Many doctors have expressed the belief that only hospital births are safe, while midwives say they often feel marginalized and disrespected.

Such studies only deepen this mistrust and have the potential to increase hostility during encounters when midwives and their clients have to seek hospital care for complications. The end result is a system that can be detrimental to women and their babies because of the impaired ability to communicate across a cultural divide. Instead of a maternity system based on fear and misinformation, we need a system based on collaboration and mutual respect.

The United States is already the butt of jokes in the international public health community. We spend more on health care than any other high-income nation, while simultaneously serving the

lowest percentage of pregnant women, as several of our key health indicators continue to decline each year. According to Eugene Declercq of the Boston University School of Public Health, the U.S. now has the highest number of maternal deaths relative to all other high-income nations, and we also rank second worst for perinatal deaths.

The U.S. has not reported a significant decrease in maternal mortality rates since 1982, and the Center for Health Statistics indicates that the rate of cesarean section in this country is now at a whopping 32 percent, marking the 11th consecutive year of increase. As the incidence of cesarean section rates rise, so do medical complications for mothers and babies, along with associated health care costs. The World Health Organization recommends a cesarean rate of no more than 10 to 15 percent, so our rate is two to three times higher than it should be.

The answer among the U.S. medical establishment has been to throw more expensive technology at the problem rather than retracing our steps to see where we went wrong. Instead of admitting that something is fundamentally broken with the system, organizations like the American College of Obstetrics and Gynecology continue to endorse the idea that medicalized hospital births are the only safe route for women.

We know that 99 percent of women in the U.S. are giving birth in hospitals, yet the United States has one of the highest infant mortality rates of any developed country, with 6.3 deaths per 1,000 babies born. Meanwhile, the Netherlands, where one-third of deliveries occur in the home with the assistance of midwives, has a lower rate of 4.73 deaths per 1,000.

While maternal mortality rates decreased among our peer nations between 2000 and 2005, they increased by more than 54 percent in the United States during the same time period. The two major differences between the U.S. and other nations, which have superior maternal and infant health outcomes, are that the latter offer universal health care and rely more extensively on cost-effective midwives as a public health strategy.

Consider the economics of the situation. The cost of a cesarean in the United States is about $15,000 and an uncomplicated vaginal birth averages $8,000 (without prenatal or postpartum care), while homebirth midwives charge $2,000 to $4,000 -- a fee that includes care from conception through the postpartum period. Exploring the option of home and birth center birth with midwives for low-risk women should be at the core of national health care reform and research. Instead, several generations of high-tech, low-touch birth and a pervasive cultural belief that birth is imminently dangerous -- even in healthy, low-risk women -- has led to powerful cultural blinders that limit options for women.

In anthropology, we say that "normal is simply what you are used to." The power of socialization and the dominance of biomedicine have kept us from systematically examining a variety of birthing environments and providers as viable alternatives to the expensive and interventive hospital delivery that has become the norm in the U.S.

Finally, I must briefly address the study by Dr. Wax and his associates. Let me first say that their study found no difference between home births and hospital births when measuring perinatal death, which is the primary indicator for evaluating the safety of a mode of delivery. Yet, the study chose instead to focus on neonatal death, generally accepted as death within the first 28 days of birth and to emphasize this part of their research. A complex mix of psychosocial and clinical factors, including congenital anomalies, Sudden Infant Death Syndrome, unsafe home environments, and poverty, can all contribute to death in the first month of life. As Dr. Michael Klein of the Child and Family Research Institute in Vancouver, B.C. points out, after removing low-quality studies and out-of-date statistics, the Wax study actually demonstrates no difference in outcomes between home and hospital-based delivery, even for neonatal mortality.

Yet the authors included faulty data in their total analysis, comparing apples to oranges by mixing different types of data sets, such as grouping low-risk with high-risk mothers, and including babies

born unintentionally at home.

As an anthropologist, I see a study like this as harmful to women and as having a much larger social impact than the authors possibly intended. For instance, there are many women in rural areas and women who are uninsured, or under-insured, whose only option is to give birth under the care of a midwife. How does this study affect these women? A study like this only exacerbates and undermines often already negative and tension-fraught relationships, making it more difficult for out-of-hospital midwives and physicians to work together when needed.

There is something to be learned from the centuries-old traditions of midwifery, and I believe that if doctors and midwives, including those who work in the home setting, could be willing to learn from and respect one another, women and babies in our country would benefit. After all, we are all working for the same end result: a happy and healthy mother and baby. Our differing visions of how to get there will require an attitude of cultural humility and a willingness to listen. Studies like the Wax study take us in the wrong direction.