

# Home Birth Matters—For All Women

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## ABSTRACT

Although it remains rare in the United States, planned home birth has drawn increasing attention and criticism in the mainstream media and has come under attack from organized medicine. Yet, recent peer-reviewed studies contribute to the evidence base supporting home birth as a safe option for low-risk women attended by skilled midwives. The author of this editorial argues that home birth is an important cultural touchstone in the landscape of American maternity care.

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*Home deliveries are for pizza, not babies.*

– Bumper sticker distributed by  
American College of Obstetrics and Gynecology

Home birth, a regrettably marginalized and underutilized practice in the United States, has long been under siege, though recently the disputes around home birth have become more heated. In the last couple of years, both the American Medical Association (AMA) and the American College of Obstetricians and Gynecologists (ACOG) have assailed not only the idea of home birth, but also the women and men who support it. The AMA, for instance, considered a motion to censure Ricki Lake for her endorsement of home birth in the 2008 documentary *The Business of Being Born* (Block, 2008). And ACOG's 2008 statement on home birth not only reiterates its "long-standing opposition to home births," but avows that ACOG "does not support programs that advocate for, or individuals who provide, home births" (ACOG, 2008, para. 1 and 2).

The ferocity of recent opposition to home birth seems curious for a number of reasons. First, there is

no evidence that home birth is enjoying a resurgence—women do not seem to be fleeing hospitals in droves. Of the more than 4 million births that take place every year in the United States, fewer than 1% are planned home births, a proportion that has not changed recently. Second, no indicators suggest that home birth has suddenly become riskier. Indeed, quite the opposite—the evidence that home birth for low-risk women attended by a skilled midwife is no less safe than hospital birth has only been growing (de Jonge et al., 2009; Gyte & Dodwell, 2008; Janssen et al., 2009).

What has changed is that home birth seems to be garnering more attention in the public arena. Recent films, including *The Business of Being Born* and *Orgasmic Birth*, a major policy symposium organized by Childbirth Connection in Washington, D.C., last spring, and two large studies published this past year in the *British Journal of Obstetrics and Gynaecology* and the *Canadian Medical Association Journal* have drawn attention in the mainstream media. Home birth has been covered in popular magazines, such as *New York* and *Time*, and on

the *Today* show on the NBC television network. The home births of celebrities including Demi Moore, Cindy Crawford, Meryl Streep, Erykah Badu, Pamela Anderson, and Julianne Moore have been discussed across the blogosphere. Although some of this coverage has been plagued by misinformation and bias—home birth has been portrayed as “extreme birth,” for example, a sobriquet that many in the birth community might feel applies more to the typical hospital birth of today—the attention to home birth has, at the very least, opened up a space for collective re-evaluation of our maternity care system.

Indeed, despite the entrenched resistance to home birth from some quarters, the reasons to rethink how and where birth takes place—in particular whether it really makes sense for all babies to be born in high-technology, intervention-intensive hospital settings—are only expanding. Let us review just a few of these here.

First, and most important, a growing body of evidence demonstrates that, for low-risk women, home birth is at least as safe as hospital birth (Gyte & Dodwell, 2008). Risk is involved wherever birth takes place; somewhat different risks accrue in different settings. The question is whether, on balance, hospital birth is safer than home birth for low-risk women.

Two recent studies make important contributions to the evidence base supporting the choice of home birth. The first, a nationwide cohort study of over half a million births in the Netherlands, concluded that “planned home birth in a low-risk population was not associated with higher perinatal mortality rates or an increased risk of admission to a NICU compared with planned hospital births” (de Jonge et al., 2009, p. 1181). The authors noted that the safety of home birth is enhanced by good referral and transportation systems, which facilitate transfer when needed. The second study used data from British Columbia on planned home births attended by registered midwives and planned hospital births meeting the eligibility requirements for home births and attended by the same cohort of midwives and a matched sample of physician-attended planned hospital births (Janssen et al., 2009). The researchers likewise found that “planned home birth attended by a registered midwife was associated with very low and comparable rates of perinatal death and reduced rates of obstetric interventions and other adverse perinatal outcomes compared with planned hospital birth attended by

a midwife or physician” (Janssen et al., 2009, p. 377).

Both studies demonstrate that among low-risk women, rates of adverse events, in particular intrapartum perinatal mortality, are very low regardless of place of birth and, furthermore, that home birth is no less safe than hospital birth, a finding that reiterates much of the previous research (Ackermann-Liebrich et al., 1996; Janssen et al., 2002; Lindgren, Radestad, Christensson, & Hildingsson, 2008; Murphy & Fullerton, 1998; Wiegers, Keirse, van der Zee, & Berghs, 1996). Moreover, each of the recent studies suggested that women who give birth at home experience lower rates of adverse maternal outcomes, especially outcomes related to obstetric interventions (de Jonge et al., 2009; Janssen et al., 2009), with the Dutch study noting that “a low intervention rate is an important indicator of optimal care as are good maternal and neonatal outcomes” (de Jonge et al., 2009, p. 1183). Indeed, one of the most recent studies of why American women choose home birth found that “safety” was among the most frequently cited reasons (Boucher, Bennett, McFarlin, & Freeze, 2009); that some women feel safer at home—out of the hospital—is not surprising, given the technology-intensive, intervention-driven process that is modern birth.

Second, sentinel events of the last decade underscore the downsides of routinely bringing new life into the world in settings otherwise dedicated to the care of the sick, where the risks of infection necessarily run high. During the SARS epidemic in Toronto in 2003, several hospitals closed their maternity wards to contain the infection (at least one hospital quarantined five newborns and their mothers for 10 days), and area midwives reported an uptick in interest in home birth among pregnant women as they came to appreciate the risks of giving birth in hospital settings (Alphonso, 2003; Calleja, 2003; Connor, 2003; Ferenc, 2003). Fears about the H1N1 virus this year have served the same purpose; indeed, many hospitals have banned all visitors under 18 years old and severely restricted adult visitors out of concerns about H1N1. For many families, hospital restrictions on visitation have delayed the joyous first meeting of newborn and

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**W** For more about the shortcomings in the news media coverage of childbirth issues, see “They Said So on the News: Parsing Media Reports About Birth” by Amy Romano, Andrea Lythgoe, and Henci Goer on pages 47–52 in this issue of the journal.

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older siblings and other extended family members. The SARS and H1N1 events remind us that hospitals ought properly to be the preserves of the sick and the individuals who care for them.

Third, the ongoing national discussion of health-care reform demands that we, as a society, reconsider “business as usual” in the health-care arena—and maternity care deserves no less scrutiny and considerably more reimagining than many other aspects of our health-care system. It is worth noting that advocates of health-care reform have focused on emphasizing primary care, controlling costs and ensuring quality, stressing evidence-based medicine and comparative effectiveness research, moving care out of the hospital and into less technology-intensive settings, and expanding the role of nonphysician providers as essential components of broad reform. All of these approaches have been long-standing goals of the movement to reform maternity care; supporting midwife-attended home birth for low-risk women has great potential to accomplish each goal.

Last but far from least, preserving home birth as an option matters not just for the women and families who prefer it, but for *all* women. Giving birth at home is decidedly not for everyone. There are important exclusion criteria, including pre-existing chronic conditions such as obesity or diabetes type 1 in the woman, pregnancy-related conditions such as pregnancy-induced hypertension, gestational diabetes or placenta previa, multiple gestations, gestational age less than 37 weeks or greater than 41 weeks, prior cesarean sections, and noncephalic presentation. For women with these risk factors and others, hospital birth is safer. Yet, advocates of home birth have never suggested that *all* women should give birth at home, only that it is a reasonable choice for some women. Given that rather modest claim, the force and vehemence with which home birth is opposed by ACOG seems out of all proportion.

In the long shadow cast by organized medicine's opposition to home birth, societal misunderstanding and even ridicule of home birth, and cultural mistrust and fear of birth generally, women who nevertheless plan to give birth at home are often ambassadors of good birth; they are impassioned, even fierce advocates of the physiologic truth that women's bodies and minds are designed to give birth. While home birth is still commonly regarded in the United States as an “extreme” choice, “out there,” and “on the fringe,” home birth nonetheless (and perhaps because of its very marginalization) remains an important cultural touchstone. Home birth presents a compelling counterexample to modern medicalized birth practices. Women who birth at home can and do deliver their babies without the obstetric armamentarium of induction, augmentation, pharmacologic pain relief, electronic fetal monitoring, and cesarean surgery that modern medicine deems “essential” for too many births. The very fact that some women prefer to give birth at home—and are able to do so—is a powerful corrective to the widespread belief that the hospital is “the only safe place” to give birth. Women who give birth at home are at once guardians of tradition and pioneers, opening our eyes to a different vision of the organization of maternity care. The existence of home birth reminds the rest of us that birth at its best—and most typical—is natural, safe, and healthy.

For me, the decision to give birth at home was not only a rational, evidence-based one, it was also an emotional, even instinctive one. I knew in the core of my being that I could give birth without drugs and without *routine* interventions—after all, hadn't millions of women been doing so for eons? I also knew that my trusted and experienced midwife would whisk me off to the hospital if necessary. (And I had the good fortune to live less than a 10-minute drive from a hospital—one where my midwife had admitting privileges, no less. Thus, I enjoyed what should be the standard, but regrettably is too often the exception in our current configuration of maternity care.)

My first child was born at a home on a gloriously sunny morning in late September after a long night of hard and painful labor. One of my happiest memories of my daughter's birthday is of sitting on my bed that afternoon, after all the phone calls to astonished grandparents had been made, after the midwife had packed up and gone home to get some sleep, and a ravenous hunger had set in, my delicious, miraculous newborn swaddled on my lap

while I hungrily devoured a pepperoni and onion pie from our favorite pizza joint. We had a home delivery, of course; the second of the day.

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