"WHAT DO THE LATEST DATA REVEAL ABOUT THE SAFETY OF HOME BIRTH IN THE UNITED STATES?"
ERROL R. NORWITZ, MD, PHD (EXAMINING THE EVIDENCE; NOVEMBER 2013)

We need honest, respectful discussion about the risks of home birth

I object to the tone of the recent commentary by Dr. Errol Norwitz. Although I agree with the concerns he raised, I object to his "tactics." The subject line of the email I received about this commentary ("Let's keep home delivery where it belongs...for pizza!") and some of the comments in the article were inflammatory and almost seem to be making fun of a topic about which many women in our country feel passionately.

As health-care providers, we are skilled at explaining risks and helping people understand how their choices and actions affect those risks. We do this daily without offering insult to patients regarding their beliefs. You don't need to convince ObGyns that home birth is unsafe—I daresay that most of them already believe that. Awareness of the data and even some of Dr. Norwitz's insights surely are valuable to the people who are actually pursuing and performing home births—but I feel that the subject line and closing remarks were mean-spirited and serve only to push practitioners and even patients—who need information to make informed decisions—farther away from what Dr. Norwitz argues is the safest care. No one responds well to mockery.

I practice the full scope of nurse-midwifery in a hospital-based practice with excellent physicians to support me and my patients. I do not attend home births, and I, too, have concerns about some home-birth practices and statistics. Honest, respectful communication about the facts is what is needed to improve patient safety and outcomes—not marginalization and disrespect.

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Dr. Errol Norwitz wonders why well-educated women are more likely to choose home birth

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NOVEMBER 2013

Hospital deliveries can have problems, too

This article was insulting. When the study by Cheng and colleagues[1] was first published, it received enormous criticism, so why has it been revived? Planned home birth with an appropriate provider is safe. The absolute numbers for maternal and newborn problems are very low but sound high when couched in warning language. Let's not forget the mothers and babies who have problems in the hospital. In fact, the United States has a terrible record when it comes to maternal and neonatal morbidity and mortality—figures based almost entirely on hospital deliveries.

Low-risk women choose home birth to avoid a delivery that often results in far too many non-evidence-based interventions. Why don't we change the system to make it work? If ObGyns would participate in a collaborative system of care that allows seamless integration of midwives into the acute-care setting when women are no longer low-risk, home-birth statistics would improve tremendously.

ObGyns are surgeons and specialists in problem-solving. Midwives are specialists in low-risk care, and they are adept at continuously assessing their patients to assure that they remain low-risk, consulting or transferring when necessary. Far too many physicians are "turf-conscious," refusing to collaborate with midwives. It sounds to me as though the risk in home birth is iatrogenic, caused by the very physicians who claim that it is unsafe.

Chris Hilderbrandt, ARNP, CNM
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Reference

1. Cheng YW, Snowden JM, King TL, Caughey AB. Selected perinatal outcomes associated with planned home births in the United States. Am J Obstet Gynecol. 2013;209(4):325.e1–e8. doi:10.1016/j.ajog.2013.06.022.

Why are real changes taking so long?

I believe that the risk figures—bolded and supersized at the beginning of Dr. Norwitz's commentary—are somewhat misleading. The intended message is clear but something very important is missing: The scores and risk values for home births were not isolated and compared between skilled midwives attending the births versus unskilled and untrained "other midwives." In that light, when one considers the difference in risk—0.37% risk for an Apgar score of less than 4 for a home birth (which involves mainly nonprofessional labor attendants) and 0.24% for a hospitalized, medically managed birth, it is remarkable that the difference—0.13%—is so small.

I realize the importance of striving to bring any risk close to zero, but the way the data were presented unfairly implies that home births are

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essentially more risky than hospital births. It simply may be that they are attended by less-skilled people.

In addition, Dr. Norwitz noted that, in countries where home birth is integrated into the health-care system, there is a twofold to threefold increase in neonatal death. However, a 2011 article by van der Kooy and colleagues[1] contradicts that claim, showing no significant difference in neonatal deaths between planned home birth and hospital birth for low-risk women in the Netherlands. I suppose, depending on the vantage point, there is a study somewhere that will support any of our beliefs.

Please make no mistake. I have never been a proponent of home birth. Even a small risk becomes 100% for the individual who suffers any kind of ill effects or damage. But I am a promoter of natural birth and minimal medical intervention. I abandoned obstetrics years ago when I saw firsthand that the increasing focus on technology and medical intervention moved the woman and her experience to the outer margins. The situation has not improved, and the strides made early on by the women's movement have all but disappeared as women are aggressively convinced that technology and "controlled" interventions will grant them safe passage. In the process, they lose a sense of their autonomy and participation in one of the most important events in their lives.

At the end of the article, Dr. Norwitz leaves us with a notion that obstetric care providers need to do more in the way of providing emotional and social support. My question is... What in the world are you waiting for?

Obstetric care has a very long way to go before the focus moves meaningfully toward handing back some of the power of choice to the pregnant woman, something early feminists championed. That would require the obstetrician to honor and listen to the woman as she begins to formulate a delivery plan, to support her input at every step of decision-making, to provide her with or refer her to sources of information about delivery alternatives—the very types of alternatives that are readily available in midwife-attended births.

Jacquelynn Cunliffe, MSN, PhD
Wayne, Pennsylvania

Reference

1. van der Kooy J, Poeran J, de Graaf JP, et al. Planned home births compared with planned hospital births in the Netherlands: Intrapartum and early neonatal death in low-risk pregnancies. Obstet Gynecol. 2011;118(5):1037–1046.

›› Dr. Norwitz responds

We all want a healthy infant

Regardless of the type of training or level of experience, all obstetric care providers want the same outcome: an uncomplicated delivery of a healthy infant under conditions that are safe and supportive.

Contrary to popular belief, Nature is not a good obstetrician. It is estimated that between 1 in 50 and 1 in 500 fetuses reach maturity in utero and are subsequently involved in a catastrophic event that results in severe neurologic damage or perinatal death.[1] Many of these catastrophic events occur during labor. Even a woman categorized as "low-risk" throughout her pregnancy can become "high-risk" in a matter of minutes if she develops a complication during labor such as cord prolapse or placental abruption. Risk factors for such intrapartum complications have been described, but these complications can develop in anyone at any time, even in women with no risk factors at all.

As noted in the letter from Dr. Cunliffe and the article by Cheng and colleagues,[2] the level of training of the person attending the planned home birth may well affect the outcome. The less skilled the provider, the less likely he or she is to anticipate and recognize a complication and the more likely an adverse event. The existing literature on this topic should not be interpreted as a criticism of the training or skill of certified nurse midwives. Even the most skilled birth attendant is ill-prepared to deal with the potential catastrophe of an intrapartum complication during a planned home birth, given the limited resources of a home environment.

The issue of planned home birth is an emotive one. Although every effort should be made to ensure that the birthing experience is a positive one, it should not be done at the expense of safety. Ms. Hilderbrandt's claim that "Planned home birth with an appropriate provider is safe" is not supported by the existing data. Even in countries where home births are integrated fully into the medical care system, such deliveries are associated with a twofold to threefold increase in the odds of neonatal death.[3] In the United States, where no such integration exists, a planned home birth is simply dangerous, although the absolute risk of a serious adverse event is low.

If a pregnant woman ever wants to know the safest place to deliver her baby, the unequivocal answer is: in a hospital setting. The question of who is best suited to attend the birth is far less critical, so long as the person—either a physician or a certified nurse midwife—has completed an accredited training program.

References

1 Feldman GB, Freiman JA. Prophylactic cesarean section at term? N Engl J Med. 1985;312(19):1264.
2 Cheng YW, Snowden JM, King TL, Caughey AB. Selected perinatal outcomes associated with planned home births in the United States. Am J Obstet Gynecol. 2013;209(4):325.e1–e8.
3. Wax JR, Lucas FL, Lamont M, et al. Maternal and newborn outcomes in planned home birth vs planned hospital births: A meta-analysis. Am J Obstet Gynecol. 2012;203(3):243.e1–e8.