

Transfer to the hospital for women planning a home birth: A high-risk obstetrics problem

👉 Do you have a written clinical guideline for pregnant women planning a home birth who are transferred to your hospital?



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CASE Febrile laboring mother transferred to hospital

You are in the hospital managing the induction of labor for one of your nulliparous patients who is postterm. You are hoping for a quiet and uneventful shift.

At midnight the nursing administrator pages you and asks if you would please provide care to a pregnant woman attempting a home birth who is in labor and is being transferred to your hospital.

The woman is a 41-year-old G2P1 with one prior cesarean delivery who has attempted a trial of labor at home. According to the nursing administrator the patient has a temperature of 100.4°F and the most recent cervical examination shows her to be fully dilated at +3/5 station in an occiput posterior position. She has been fully dilated for 5 hours. The fetal heart rate, assessed by Doppler monitor, is reported to be reassuring.

What is your clinical plan?

rates above 1.9%, including Montana (2.6%), Oregon (1.96%), and Vermont (1.91%). Five states had home birth rates above 1.5%, including Idaho, Pennsylvania, Utah, Washington, and Wisconsin.⁴ Because planned home births may require transport to the hospital to complete the birth, all obstetric units should develop written plans for dealing with these high-risk patients.

Hospital transfer is common for women attempting a home birth

Many home birth experts regard the Netherlands as the country with the best organized and most successful home birth system that is fully integrated with hospital-based obstetric care. Approximately 23% of births in Holland occur at home supervised by a midwife. A key feature of the highly regulated Dutch system is that all pregnant women with a high-risk condition are required to give birth in a hospital and cannot have a home delivery. Consequently, only women with a low-risk pregnancy are permitted to attempt a home birth.

The American College of Obstetricians and Gynecologists and the American Academy of Pediatrics recommend that pregnant women should deliver at certified birth centers or hospital-based obstetric units to optimize clinical outcomes for newborns and mothers.^{1,2} Both organizations also recognize a woman's right to exercise her autonomy and choose a planned home birth.

In 2012, approximately 0.8% of pregnant women in the United States had a home birth (31,500 home births and 3,999,386 total births).³ In 2009, three states had home birth

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By contrast, in the United States, with a less well-regulated home birth system, women with high-risk conditions, such as one or more prior cesarean deliveries, may try to birth at home. **In a Dutch study of 168,618 low-risk women attempting a home birth, 32% (n = 53,809) were transferred to the hospital.** Most of the transfers occurred during labor.⁵

In England about 2.8% of births occur at home. In a study of 16,840 planned home births in England, 21% (n = 3,530) of the women were transferred to the hospital.⁶ Of the 3,530 transfers to the hospital, 70% were transferred before delivery and 30% after birth. **In this study among 4,568 nulliparous women attempting home birth, 45% were transferred to the hospital.** Among 12,272 multiparous women attempting home birth, 12% were transferred to the hospital.

Among the nulliparous women, but not among the multiparous women, there was a significantly increased risk of adverse newborn outcomes. Adverse newborn outcome was a composite measure that included perinatal death, stillbirth after the onset of labor, neonatal encephalopathy, meconium aspiration syndrome, brachial plexus injury, or fractured humerus or clavicle. The risk of an adverse newborn outcome among nulliparous women was 0.9% for those delivering at home and 0.5% for those delivering at the hospital.⁶

Interprofessional team care

For the woman planning a home birth, transfer from home to the hospital is a jarring experience. The woman may feel that she has not achieved a highly desired and important life goal. In a survey of women birthing in the Netherlands, transfer from home to the hospital was associated with

Your patient asks you, “Are home births safe for the baby?”

No large-scale randomized trials have compared home birth versus hospital birth.¹ Consequently, the best evidence evaluating the risks and benefits of home birth is based on observational studies of large cohorts. Recent studies from the United States have reported that neonatal complications, including the risk of a low Apgar score and neonatal seizures, is significantly increased with planned home birth compared with birth at a hospital.^{2,3} In one study, the risk of a 5-minute Apgar score of zero was one in 615 home births and one in 6,493 hospital births.³ Studies from the Netherlands also have reported that planned home birth is associated with increased perinatal mortality and morbidity.^{4,5}

Because planned home birth is associated with an increased risk of neonatal morbidity and mortality, some experts conclude that obstetricians have an ethical obligation to recommend against home birth and to respond to refusal of that recommendation with respectful persuasion.⁶

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a high rate of patient dissatisfaction with their birthing experience. Compared with women who were satisfied with their birth experience, women who were dissatisfied more often reported that the care providers at the hospital were rushed, insensitive, rude, inconsiderate, condescending, and unhelpful.⁷

Creating a positive birthing experience

Given that transfer to the hospital is associated with an increased rate of being dissatisfied with the birth experience, and that dissatisfied women may perceive their care providers negatively, it is important for the interprofessional hospital team to devote adequate time to listen to the patient's concerns, demonstrate a high degree of sensitivity, and be especially polite and helpful. It is

probably best to avoid referring to the transfer as a “failed home birth.” Trust may be enhanced by asking open-ended questions about the patient's expectations and expressing empathy for her situation. The hospital professional team might prioritize acknowledging the right of the woman to make informed choices and provide an overview of the standard procedures used at the hospital. The clinicians should explicitly state that the health of the mother and newborn are their top priority. The hospital team should also express confidence in the benefit of the standard practices they use to ensure a safe birth experience.

Successful negotiation: An art best achieved as a small group

When a laboring woman is transferred from home to the hospital, a

negotiation begins with the hospital professionals about the best clinical path to a successful birth. The patient often arrives with a support team that includes her partner, a support person, and a midwife or trained birth attendant. These individuals often demonstrate strong group cohesion and may be skeptical of the benefits of hospital birthing practices including intravenous access, oxytocin administration, epidural anesthesia, and operative delivery. The goal for the patient and her support team and the hospital professionals is to achieve a safe birth for the baby and mother. Because the goal is aligned among all parties, the negotiation is focused on the clinical path that will best achieve the goal with minimal risks.

To enhance the likelihood of a successful negotiation, it is best if the team of hospital professionals, including an obstetrician, a senior nurse, and an obstetric

anesthesiologist, jointly discuss hospital birthing practices with the patient and her support team. An obstetrician, negotiating independently, is in the difficult position of one professional trying to redirect the choices of a cohesive team of four individuals. Most experienced negotiators would not voluntarily enter a situation in which acting alone they needed to simultaneously negotiate with four people. A joint discussion between the interprofessional team and the patient reduces the opportunity for the patient and her team to generate disagreements among the hospital professionals.

An important issue is that the home midwife or trained birth attendant is not permitted to participate in the practice of medicine at the hospital. Only credentialed and licensed nurses, obstetricians, anesthesiologists, and pediatricians are permitted to participate in the practice of medicine at the hospital.

It may be prudent to provide the home midwife a written statement from the hospital indicating that home midwives are not permitted to practice medicine at the institution.

Occasionally, negotiations between the hospital professional team and the patient and her support team are unsuccessful and the patient refuses the best advice of the hospital team. In these situations there should be a written plan of how the patient–clinician conflict will be communicated to other members of the hospital staff and hospital leadership. For example, another senior clinician may be asked to join in the planning process.

A high-risk patient population

In some cases of planned home birth, the patient and midwife have made management decisions that are inconsistent with standard obstetric

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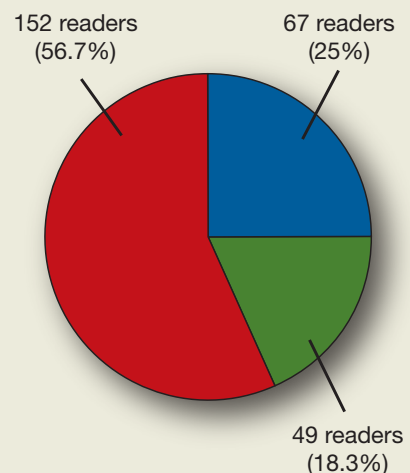
Online poll results suggest that many obstetricians offer aspirin for preeclampsia prevention in women with prior preeclampsia

A recent OBG MANAGEMENT online poll took as its subject Dr. John Repke's guest editorial on "Low-dose aspirin and preeclampsia prevention: Ready for prime time, but as a 're-run' or as a 'new series'?" In it, Dr. Repke described his practice of discussing the option of initiating low-dose aspirin as early as 12 weeks' gestation for patients who had either prior early-onset preeclampsia requiring delivery before 34 weeks or preeclampsia during more than one pregnancy.

Our poll asked how many responders had the same practice. Almost 300 readers responded:

- **152 readers (56.7%)** reported matching the practice of Dr. Repke—offering low-dose aspirin in the late first trimester (after 12 weeks)
- **67 readers (25%)** reported waiting for more data before offering low-dose aspirin to prevent preeclampsia
- **49 readers (18.3%)** reported offering low-dose aspirin later in the pregnancy (16–20 weeks)

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protocols. Commonly encountered situations include **1)** prolonged conservative home management of spontaneous rupture of the membranes at term, **2)** prolonged conservative management of the arrest of the active phase of the first stage of labor, **3)** prolonged second stage of labor, up to 24 hours in length, and **4)** attempted home birth after multiple previous cesarean deliveries. I am also aware of multiple reports of attempted home birth of a fetus in the breech presentation.

On arrival to the hospital these patients and their newborns are at exceptionally high risk for adverse birth

outcomes. If an adverse outcome were to occur, it would be unjust to assign sole or primary responsibility to the obstetrician for the adverse outcome. Hence, the hospital should have a written plan for helping to minimize the risk that the obstetrician, playing the role of Good Samaritan, will bear primary responsibility for an adverse outcome.

CASE Resolved

In the case presented above, the obstetrician, nurse, and obstetric anesthesiologist successfully negotiated with the patient. Intravenous access and an epidural anesthetic

were established. Antibiotics were administered. Using ultrasound, the obstetrician confirmed that the fetus was in the occiput posterior position. The mother was exhausted from many hours of pushing and agreed to an operative delivery. Forceps were used to deliver a healthy baby and a perineal laceration was repaired. 🍷



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