"DOES HOME BIRTH EMPOWER WOMEN, OR IMPERIL THEM AND THEIR BABIES?"
ERIN E. TRACY, MD, MPH (AUGUST)

Evidence points to safety of home birth

As experts in "normal" birth and home birth, we are concerned about the disregard for fact and evidence that is apparent in Dr. Tracy's article, and we feel it is our duty to clarify the incorrect statements, offering published scientific evidence to back up our assertions.

We would like to make three main points:

1. Important data were overlooked

Numerous scientific articles published over the past 20 years have documented the safety of home birth. One of the most notable scientific articles on the subject was authored by de Jonge and colleagues.[1] It includes retrospective data on more than 500,000 women and found no difference in the rate of perinatal mortality or morbidity between planned home birth and planned hospital birth.

In addition, a study by Johnson and Daviss analyzed prospective data from 5,418 women who expected to deliver at home under the care of a Certified Professional Midwife.[2] The results: Planned home birth for low-risk women in North America was associated with a lower rate of medical intervention than conventional care (low-risk women in hospitals) but similar rates of intrapartum and neonatal mortality.

2. CPM credential requires testing, training

In regard to the training required to attain the Certified Professional Midwife (CPM) designation, it is necessary to pass a professional licensing exam in addition to undergoing training and credentialing to offer expert

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and evidence-based out-of-hospital care. The CPM credential requires the midwife to master clinical and didactic skills, demonstrate the acquisition of knowledge and skills, and perform competently under supervision.

CPM certification is renewed every 3 years, and all CPMs must obtain continuing education and participate in peer review. The CPM credential meets the standards established for educational testing required by the American Education Research Association and the National Council on Measurement of Education. The CPM is credentialed through the North American Registry of Midwives and is accredited through the National Association of Certifying Agencies. The latter promotes excellence in competency for practitioners, including the Certified Nurse Midwife.

3. ACOG should work for women's empowerment, too

Dr. Tracy says that women who choose home birth "because of impassioned rhetoric about empowerment and choice may be deeply disappointed if it goes awry and transfer to the hospital is needed." According to Johnson and Daviss,[2] only 12% of women who planned a home birth had to be transferred to a hospital. This leaves 88% of women impassioned and empowered by their safe choice. It also is worth noting that women who transfer to the hospital from a planned home birth in the United States often face a hostile reception from hospital personnel.[3,4] Perhaps their disappointment emerges from this disrespectful treatment. We are also curious as to why empowerment and choice are not considered indicators of quality of care for a professional organization—ACOG—that works to "serve as a strong advocate for quality health care for women."

We urge Dr. Tracy, as a member of ACOG's Working Group on Midwifery, to review the current scientific research on home birth and professional midwifery to better understand the safety of home birth and the reasons "home birth isn't going away."

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References
1. de Jonge A, van der Goes BY, Ravelli ACJ, et al. Perinatal mortality and morbidity in a nationwide cohort of 529,688 low-risk planned home and hospital births. BJOG. 2009;116:1177–1184.
2. Johnson KC, Daviss BA. Outcomes of planned home births with certified professional midwives: large prospective study in North America. BMJ. 2005;330:1416.
3. Cheyney M, Everson C. Narratives of risk: speaking across the hospital/homebirth divide. Anthropology News. 2009; 50(3):7–8.
4. Davis-Floyd R. Home-birth emergencies in the US and Mexico: the trouble with transport. Social Science & Medicine. 2009;56(9):1911–1931.

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Some women choose home birth to avoid cesarean delivery

Although I believe Dr. Tracy's comments on home birth are justified, and her heart is sincere, I also believe she left out a huge piece of the puzzle: the over-use of cesarean section.

I have experienced cesarean deliveries, although my babies were never distressed—in fact, they were born with perfect Apgar scores. I was forced to have one cesarean section because my baby was not born within the doctor's desired time frame.

In two of my cesarean deliveries, I was damaged in ways that could have justified a lawsuit, if I were the suing type. In one, a main artery was accidentally nicked. I bled a lot, was given two transfusions, and had to stay in the ICU all night. I was not even told about the problem until I asked why there was "red stuff" in my IV.

The other injury involved my intestines, which were somehow manipulated during the surgery. After the operation, I had a bulge like a water balloon below my navel. Both of these operations were forced upon me as "safe and necessary."

Doctors are scaring women into staying home to have their babies! But not every woman's body can deliver a baby "on schedule." As long as everything is going fine, there is no reason to intervene in the woman's natural process of giving birth.

Please make the same effort you did to warn women about attempting home birth to warn doctors that they are the biggest reason this is happening. Any woman in her right mind would choose to be in a hospital "just in case" there was an emergency, especially those who desire vaginal birth after cesarean delivery. Believe me, I am one of those women.

Angela Prowant
Adams, Tenn

Skill of attendant is critical in home birth

I appreciated Dr. Tracy's comprehensive article on home birth. As someone who has attended many home births in a rural situation, I agree that the training, skill, and experience of the attendant are the most important variables. Because the selection of patients for home birth is dependent on the attendant's experience in obstetrics, the so-called Certified Professional Midwife classification should be eliminated and only well-trained Certified Nurse Midwives should be allowed to attend home births.

Henry Bramanti, MD
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›› Dr. Tracy responds:

Lack of randomized, controlled data is a problem

The literature on home birth is flawed and often involves limited outcome measures. There is only one randomized, controlled trial of the practice—and it is very small.[1] As for the articles referenced in the letter from the Midwives Alliance of North America, they aren't necessarily generalizable to the US population. The study by de Jonge and colleagues, for example, involves women in the Netherlands, where home-delivery practices are clearly outlined.

In the Netherlands, home birth requires:

- *qualified, well-trained attendants*
- *strict transfer criteria*
- *formal collaborative arrangements between providers*
- *close geographic proximity to local health-care facilities*
- *strict exclusion criteria (including the presence of meconium).*

None of these variables apply to the US population.

In the United States, geographic challenges are real. (The skill of attendants will be discussed a little later.) Many midwives practice with no formal transfer arrangements with specific institutions or providers, and there are no defined, universally accepted criteria for transfer or exclusion from home delivery.

The Johnson and Daviss article is often heralded because this study of 5,418 women resulted in no maternal fatalities. The maternal-fatality rate in this country is 8 in every 100,000 women.[2] The zero mortality rate found by Johnson and Daviss is therefore not surprising. This study was also underpowered to detect any meaningful change in neonatal mortality. One would also hope that women who are deemed to be at low risk of complication would have better outcomes and less need for medical intervention than those who self-select to seek physician care.

CPM training is insufficiently rigorous

In regard to the CPM credential, the presence of a certifying examination doesn't replace the need for adequate clinical training. Only experience and volume enable providers to learn to recognize obstetric complications and provide appropriate treatment. Exam-

Instant Poll Results

When to avoid intrauterine contraception

Of the populations and conditions listed in the question on page 10, only **acute pelvic infection** and **severe distortion of the uterine cavity** are contraindications to intrauterine contraception

inations are limited in their ability to evaluate providers' competence in real time, in clinical scenarios. The CPM credential requires only minimal clinical exposure, as spelled out on the Web site of the North American Registry of Midwives:

> As an active participant, you must attend a minimum of 20 births....Functioning in the role of primary midwife under supervision, you must attend a minimum of an additional 20 births:
>
> A. A minimum of 10 of the 20 births attended as primary under supervision must be in homes or other out-of-hospital settings; and
>
> B. A minimum of three of the 20 births attended as primary under supervision must be with women for whom you have provided primary care during at least four prenatal visits, birth, newborn exam, and one postpartum exam.[3]

Indeed, the experts on midwifery care, the American College of Nurse-Midwives, recently sent letters to members of Congress objecting to the recognition of the CPM credential, noting, "Accreditation of the certifying body... is not the same as requiring graduation from a formal accredited educational program prior to taking the certification exam."[4] This letter goes on to rightly note, "As a nation with a well developed health care infrastructure, the US should lead the way in professional standards—not accept a lesser standard for midwifery than any other health care profession."

Many variables contribute to high cesarean-delivery rate

In regard to Ms. Prowant's concerns about the rate of cesarean section, I suspect I speak for most obstetricians when I echo her trepidation. As a patient myself, I was happy that I didn't need a major abdominal surgery for my own deliveries, and I fully support women's desire to experience natural childbirth without any medical intervention.

One mustn't forget, however, the many variables that contribute to this country's cesarean-delivery rate:

- *the worsening American obesity epidemic*
- *the litigious society in which we live*
- *the increased number of women with multiple gestations*
- *the advent of elective cesarean section by patient choice.*

The increasing age at which women reproduce in this country is also associated with multiple risk factors that increase the risk of fetal intolerance of labor and labor dystocia, including placental insufficiency, diabetes, and hypertension.

That said, obstetricians are committed to addressing variables that are within our control, and ACOG even created a Task Force on the Cesarean Delivery Rate in 1997, which published a monograph outlining the issue in great detail.[5]

The burden of proof in establishing safety of health-care delivery in the absence of immediate access to potentially life-saving medical or surgical interventions must reside with those who advocate for home birth. While there are some data that demonstrate no increased risk, other data reveal the opposite, as outlined in my article. In the interim, patients should be educated about all of these issues, including the limitations of services in the home setting, the recognized potential for emergent transfer with the potential for adverse outcomes in the process, and the educational level and background of their health-care providers.

I suspect that those of us who have concerns about this practice support women's empowerment and the right to make choices, but safety should be the driving concern in all of these debates. The setting of delivery can't be held paramount over the safety of the mother and baby. The stakes are simply too high.

References

1. MacVicar J, Dobbie G, Owen-Johnstone L, et al. Simulated home delivery in hospital: a randomized controlled trial. Br J Obstet Gynaecol. 2003;100:316–323.

2. Maternal mortality. Available at: www.nationmaster.com/graph/hea_mat_mor-health-maternal-mortality. Accessed Oct. 20, 2009.

3. North American Registry of Midwives position statement: educational requirements to become a certified professional midwife (CPM). Available at: www.narm.org/htb.htm#edrequirements. Accessed Oct. 20, 2009.

4. Special alert to ACNM members: recent developments related to attempts to provide federal recognition to all CPMs. Available at: www.midwife.org/documents/ACNMLettertoMembership_FederlRecgnitionofCPMS.pdf. Accessed Oct. 20, 2009.

5. American College of Obstetricians and Gynecologists. Evaluation of Cesarean Delivery. Washington, DC: ACOG; 1997.