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## Features

# Planned Home Birth in the United States and Professionalism: A Critical Assessment

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### ABSTRACT

Planned home birth has been considered by some to be consistent with professional responsibility in patient care. This

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article critically assesses the ethical and scientific justification for this view and shows it to be unjustified. We critically assess recent statements by professional associations of obstetricians, one that sanctions and one that endorses planned home birth. We base our critical appraisal on the professional responsibility model of obstetric ethics, which is based on the ethical concept of medicine from the Scottish and English Enlightenments of the 18th century. Our critical assessment supports the following conclusions. Because of its significantly increased, preventable perinatal risks, planned home birth in the United States is not clinically or ethically benign. Attending planned home birth, no matter one's training or experience, is not acting in a professional capacity, because this role preventably results in clinically unnecessary and therefore clinically unacceptable perinatal risk. It is therefore not consistent with the ethical concept of medicine as a profession for any attendant to planned home birth to represent himself or herself as a "professional." Obstetric healthcare associations should neither sanction nor endorse planned home birth. Instead, these associations should recommend against planned home birth. Obstetric healthcare professionals should respond to expressions of interest in planned home birth by pregnant women by informing them that it incurs significantly increased, preventable perinatal risks, by recommending strongly against planned home birth, and by recommending strongly for planned hospital birth. Obstetric healthcare professionals should routinely provide excellent obstetric care to all women transferred to the hospital from a planned home birth. The professional responsibility model of obstetric ethics requires obstetricians to address and remedy legitimate dissatisfaction with some hospital settings and address patients' concerns about excessive interventions. Creating a sus-

tained culture of comprehensive safety, which cannot be achieved in planned home birth, informed by compassionate and respectful treatment of pregnant women, should be a primary focus of professional obstetric responsibility.

## INTRODUCTION

Home births have increased in the United States by 29 percent, from 2004 to 2009.<sup>1</sup> The American College of Obstetricians and Gynecologists (ACOG) has stated that pregnant women have a right to elect planned home birth.<sup>2</sup> The Royal College of Obstetricians and Gynaecologists (RCOG) goes further and explicitly endorses planned home birth.<sup>3</sup> These statements make the implicit assumption that planned home birth is compatible with professional responsibility for pregnant and fetal patients in the intrapartum period (occurring during childbirth). The purpose of this article is to show that such an assumption lacks scientific and ethical justification and that therefore attendance at planned home birth is a violation of professional responsibility.

Professional responsibility is an essential component of all of clinical ethics. In planned home birth, this is especially the case, as we will show in this article. We therefore begin with an account of the ethical concept of medicine as a profession and its origins in the Scottish and English Enlightenment. On this basis, we then set out the components of the professional responsibility model of obstetric ethics and contrast it with the maternal-rights-based reductionist model. We then provide a critical appraisal of the assumption in the ACOG and the RCOG statements that planned home birth is compatible with professional responsibility in obstetric care. We also show that the ineliminable, clinically unnecessary and therefore clinically unacceptable intrinsic perinatal risks of the home setting mean that attendants at planned home birth, regardless of their training, cannot justifiably consider themselves to be professionals or claim to be engaging in professional obstetric care. We conclude by identifying the implications of the professional responsibility model for planned hospital birth.

### THE PROFESSIONAL RESPONSIBILITY MODEL OF OBSTETRIC ETHICS, AN ESSENTIAL COMPONENT OF THE ETHICS OF PLANNED HOME BIRTH

The professional responsibility mode of obstetric ethics has major implications for the ethics of planned home birth. The professional responsibility model of obstetric ethics is based on the ethical

concept of medicine as a profession.<sup>4</sup> When in the history of Western medical ethics did this concept originate? Many physicians and clinical ethicists believe that medical professionalism has roots in the Hippocratic Oath and other ethical texts in the Hippocratic Corpus.<sup>5</sup> However, the Hippocratic Oath can reasonably be read as a guild oath, the primary purpose of which was to secure the fealty of young men who were not the sons of physicians. “It is clear that the essential role of the Oath was to preserve the interests and privileges of the family possessing medical knowledge from the moment it was made available to others.”<sup>6</sup> The entire first section of the Hippocratic Oath stipulates the obligations of these young men to their masters in the guild, solemnized in a “written contract,”<sup>7</sup> that is, a loyalty oath.

Obstetric practice figures prominently in the prescriptions and proscriptions that follow, which are not explained but can be read as self-interested; for example, avoiding high mortality rates and the ruined reputation that they bring in their wake to physicians whose patients die in high numbers. In ancient Greek medicine, a pessary was a stone placed in the cervix of a pregnant woman to cause it to dilate, resulting in uterine contractions that caused an induced abortion. In an era innocent of infection control and aseptic pessaries (which we now have), pessaries became major sources of infections for women and subsequent deaths.

The oath calls for the protection of *techné*. This term is wrongly translated as the “art” of medicine, in contrast to the science of medicine, because *techné* names the “science” of medicine. We use the scare quotes to indicate that *techné* is not science, but a fixed, unchanging, and unchangeable set of knowledge about the four humors and their imbalances, and the clinical skills of diagnosing the course and severity of diseases and injuries and intervening very modestly to alter that course.<sup>8</sup> This is not science as we know it. To make the Hippocratic Oath and accompanying texts the basis of professionalism in medicine is very odd, indeed.

Suppose, to the contrary, that the Hippocratic Corpus does indeed present a concept of medicine as a profession—rather than an unchanging, self-interested guild—that comes down to us intact from ancient Greece in what is usually invoked as the “Hippocratic Tradition.” Robert Baker has dubbed this view the “Hippocratic footnote,” and discredited it.<sup>9</sup> The historical problem is that there was no Hippocratic tradition, as Vivian Nutton has shown.<sup>10</sup> The oath fell out of favor in the early centuries of the Common Era. In medieval and Renaissance uni-

versities, graduates in medicine took an oath of loyalty to the faculty. Nutton argues that the mid-20th century witnessed a conservative reaching back to the revered founder of Western medicine, to valorize a set of values that did not originate in ancient Greece. Galvão-Sobrinho has argued that this has been a common use of the historical figure of Hippocrates. His name and the works that bear his name have been invoked to valorize views that the Hippocratic physicians would not recognize and are even incompatible with the content of the Hippocratic texts.<sup>11</sup>

The ethical concept of medicine as a profession originated in the Scottish and English Enlightenment.<sup>12</sup> Two physician-ethicists, John Gregory (1724-1773) of Aberdeen and Edinburgh in Scotland, and Thomas Percival (1740-1804) of Warrington and Manchester in England, invented the ethical concept of medicine as a profession. They did so precisely in response to the guild mentality that had come to dominate Western medicine. The individual and group self-interest was epitomized in the Statuta Moralia of the Royal College of Physicians in London. These “moral statutes” were designed to promote the self-interest of physicians in such matters as cultivating good reputations by never criticizing each other in public.<sup>13</sup> At that time, there was no accepted science of medicine, and therefore no accepted educational pathway into medical or surgical practice. Indeed, there were almost as many concepts of health and disease and treatments as there were physicians, who competed fiercely for the small private-practice market in the homes of the well to do. Gregory and Percival also wrote their medical ethics in response to the crisis of trust of the sick. As Dorothy and Roy Porter have convincingly documented from magisterial research on 18th-century primary sources, sick persons did not trust physicians, surgeons, and apothecaries (forerunners of modern pharmacists) intellectually, to know what they were doing, or morally, to be more concerned about the well-being of the sick than with lining their pockets with the money of the sick.<sup>14</sup> In present times, many pregnant women who elect home birth do so on the basis of trust in their attendants. This intellectual and moral trust is warranted if and only if those attendants can justifiably be regarded as healthcare professionals.

Gregory and Percival’s invention of the ethical concept of medicine and its commitments warranting the intellectual and moral trust of patients bear directly on the ethics of planned home birth. Gregory and Percival set out to reform medicine into the profession that it has become over the past two

centuries. They did so by turning to the best scientific method of their day: Baconian, experience-based medicine (a forerunner of what is now known as evidence-based medicine, or, better, the deliberative practice of medicine) and the best moral science of their day: Gregory to David Hume’s sympathy-based moral science and philosophy (1711-1776) and Percival to Richard Price’s (1723-1791) intuition-based moral science and philosophy.<sup>15</sup>

Using these intellectual resources, they forged a three-component ethical concept of medicine as a profession. First, physicians should commit to becoming and remaining scientifically and clinically competent. Second, physicians should use their scientific and clinical competence primarily to protect and promote the health-related interests of patients, keeping individual self-interest systematically secondary. Third, physicians should commit to sustaining medicine as a public trust (the phrase is Percival’s) that exists primarily for the benefit of patients and society, keeping group or guild self-interest systematically secondary.<sup>16</sup> The result was to transform physicians from incompetent, self-interested practitioners into professional physicians. The sick were transformed into patients. Thus was introduced into the history of medical ethics the physician-patient relationship that is primarily fiduciary and not primarily contractual in nature.

The professional virtue of integrity is based in the ethical concept of medicine as a profession. Professional integrity comprises two commitments. The first is to intellectual excellence that is achieved by making the first commitment in the ethical concept of medicine as a profession. The second is to moral excellence that is achieved by making the second and third commitments in the ethical concept of medicine as a profession. Professional integrity sometimes requires healthcare professionals to protect patients from themselves.<sup>17</sup> In this respect, the ethical concept of medicine is justifiably paternalistic in nature: it rests on the assumption that scientific and clinical competence creates expertise about healthcare that the typical patient does not possess.

The ethical concept of being a patient is a function of the ethical concept of medicine as a profession. A human being becomes a patient when that human being is presented to a physician or other healthcare professional and there exist forms of clinical management that are reliably expected in deliberative (evidence-based, rigorous, transparent, and accountable) clinical judgment to result in net

clinical benefit for that human being. The ethical concept of being a patient is beneficence based.<sup>18</sup>

The professional responsibility model of obstetric ethics applies the ethical concept of medicine as a profession to obstetric care.<sup>19</sup> The focus of this article is on planned home birth, which, by definition, occurs at the end of pregnancy. During the intrapartum period, the obstetric healthcare professional has two patients, the pregnant patient and the fetal patient, when the pregnant woman presents for care. The obstetric healthcare professional therefore has beneficence-based obligations to both the pregnant patient and fetal patient to protect and promote their health-related interests. The obstetric healthcare professional also has autonomy-based obligations to the pregnant woman. These obligations focus on empowering the pregnant woman with information that she needs to make decisions with her obstetric healthcare professional about the management of her pregnancy. The obstetric healthcare professional must in all cases take into account and balance beneficence-based and autonomy-based obligations to the pregnant patient and beneficence-based obligations to the fetal patient. This ethically complex relationship means that the fetal patient is not a separate patient, that is, beneficence-based obligations to the fetal patient are a part of, but not the entirety of, the ethical relationship between the obstetric healthcare professional and the pregnant patient and fetal patient.<sup>20</sup>

The professional responsibility model stands in sharp contrast to what we have elsewhere described as the maternal-rights-based reductionist model of obstetric ethics.<sup>21</sup> In the rights-based reductionist model, the pregnant woman's autonomy is the conclusive ethical consideration throughout pregnancy. She has an absolute right to bodily integrity, unconstrained by any ethical obligations to the fetus. The fetus is not a patient on this account and is ethically inseparable from the pregnant woman, the only patient in the rights-based reductionist model of obstetric ethics. This model has important implications for the relationship between the pregnant woman and the obstetric provider. The relationship is purely contractual, because the sole basis of the relationship is the exercise of the pregnant woman's autonomy. In the professional responsibility model, the pregnant woman's right to bodily integrity is not absolute; it is justifiably constrained by professional integrity.

The maternal-rights-based reductionist model has a radical implication that its advocates ignore. In such a model of healthcare, there are no patients. There are only sick individuals (*aegtorus* in the

Latin texts that precede Gregory and Percival in the history of Western medical ethics, in which there is no word that is reliably translated in English as "patient") or clients who contract with providers. There are no healthcare professionals, because rights-based-reductionist models embrace an absolute right to the bodily integrity of the client, which eliminates professional integrity as an ethically justified constraint on the client's autonomy, because it prevents the physician from intervening in a professional manner. In the technical language of philosophy, the maternal-rights-based reductionist model, when it continues to use the language of "patient," is impermissibly parasitic on the professional responsibility model, which, as a matter of the logic of concepts, the rights-based reductionist model must reject.

#### **CRITICAL APPRAISAL OF THE ASSUMPTION THAT PLANNED HOME BIRTH IS COMPATIBLE WITH PROFESSIONAL RESPONSIBILITY**

We began this article with references to statements by professional obstetric associations of physicians. The ACOG sanctions the right of a pregnant woman to select the birth setting,<sup>22</sup> while the RCOG goes further and explicitly endorses planned home birth.<sup>23</sup> Both statements implicitly assume that planned home birth is compatible with professional responsibility to the pregnant patient and fetal patient in the intrapartum period of term pregnancies. We disagree and turn now to a critical appraisal of this implicit assumption.

We do so on the basis of our previous analyses of planned home birth and a new data analysis that was not available to either the ACOG or the RCOG. In our previous analyses we have shown that planned home birth, because the ineliminable risk of emergency transport of laboring women to the hospital, there is an increased risk of adverse perinatal outcomes.<sup>24</sup> We have recently reported the results of a new analysis of the U.S. Centers for Disease Control's National Center for Health Statistics birth certificate data files for the period 2007-2010 that strongly corroborates our earlier analyses.<sup>25</sup> The resulting study population of more than 13 million births is the largest study population to date.

Our analysis focused on relative risk, the ratio of the occurrence of an event in the group exposed to a form of clinical management—planned home birth in this case—versus the occurrence of an event in the non-exposed group—hospital birth in this case. Relative-risk analysis is commonly used in comparative analysis of outcomes. We demonstrated

a relative risk of 10.55 for five-minute Apgar scores of zero for home versus hospital birth, which increases to 14.24 for nulliparous women (women who have not previously given birth). The relative risk of seizures and other neurologic disorders was 3.80 for home versus hospital birth, which increased to 6.28 for nulliparous women. These increased risks result in clinically significant perinatal mortality and morbidity that can be prevented by hospital birth. These perinatal risks therefore become clinically unnecessary to impose on the fetal and neonatal patients, who cannot consent to them. There is an obvious beneficence-based obligation and therefore professional responsibility to prevent such unnecessary clinical risks to fetal and neonatal patients when there is a safe and effective alternative. That alternative is a planned hospital birth, which, our analysis indicates, significantly decreases perinatal morbidity and mortality. Given the clinically unnecessary violation of beneficence-based obligations to the fetal and neonatal patient, any claim that the home birth setting is compatible with professional integrity founders on these data.

In light of this new data analysis and its ethical implications, it becomes apparent that the ACOG statement suffers from internal inconsistency. First, the ACOG's position, in effect, holds that the pregnant woman's right to select her preferred birth setting at home should be recognized, even though the ACOG recommends against planned home birth.<sup>26</sup> The ethical implication of the new data analysis that we have just described is that one cannot sanction the right of a pregnant woman to select a birth setting that is inconsistent with professional integrity and responsibility without taking the view that such a right is unconstrained by professional integrity and responsibility. Yet the ACOG is committed to the professional integrity of obstetric practice. Second, in sanctioning such a right, the ACOG has implicitly invoked the maternal-rights-based reductionist model. In simultaneously recommending against planned home birth, the ACOG has implicitly invoked the professional responsibility model. As is clear from the above account of the two models, the two models cannot be invoked simultaneously.

In light of the new data analysis and its ethical implications, the RCOG's problem is more serious. By endorsing planned home birth, the RCOG has implicitly embraced the view that planned home birth is consistent with professional integrity and responsibility.<sup>27</sup> The clinically significant and unnecessary increased relative perinatal risks of planned home birth rule out such consistency.

As professional associations of obstetricians, the ACOG and the RCOG should be committed to the professional responsibility model of obstetric ethics. Our clinical and ethical analysis of the CDC data support the conclusion that planned home birth is not compatible with professional integrity and therefore professional responsibility in patient care. In light of the new data analysis and its ethical implications, both the ACOG and the RCOG should reconsider their statements on planned home birth. The RCOG now needs to justify its endorsement of planned birth both scientifically and ethically. Both the ACOG and the RCOG should unequivocally recommend against planned home birth. They should also be clear that no obstetrician should participate in planned home birth, because this would be facilitating clinically unnecessary, unsafe delivery, which is incompatible with professional integrity. Both the ACOG and the RCOG should be explicit that intentionally facilitating unsafe clinical practice of any kind is not permitted in professional medical practice.

The ACOG now needs especially to justify scientifically and ethically its sanction of planned home birth, because, as planned home birth has increased in frequency, clinically unnecessary risks of adverse perinatal outcomes have also increased. Neither the ACOG nor the RCOG sanction a woman's right to smoke or consume spirit beverages during pregnancy, and both explicitly recommend against these behaviors during pregnancy.<sup>28</sup> Any obstetrician who were to endorse or even sanction such clinically unsafe and unnecessary practices as smoking or drinking alcohol by pregnant patients would be justifiably regarded as acting inconsistently with professional responsibility. *Mutatis mutandis*, attendants at planned home birth, no matter their training or experiences, should not be regarded as acting consistently with professional responsibility. It follows that planned home birth should not be endorsed or even sanctioned by any professional obstetric organization.

#### **PLANNED HOME BIRTH ATTENDANTS ARE NOT ACTING IN A PROFESSIONAL CAPACITY**

The ethical concept of medicine has an important and heretofore unidentified implication for planned home birth. In light of the new data analysis, planned home birth is not consistent with the first commitment in the ethical concept of medicine as a profession. Scientifically and clinically competent provision of obstetric services requires

the capacity to diagnose and prevent obstetric complications. Scientifically and clinically competent provision of obstetric services also requires the ability to diagnose and respond quickly and effectively to unexpected obstetric emergencies. No such capacities exist in planned home birth. This clinical reality is not a function of who the attendant is. Instead, the setting of planned home birth is itself determinative, because, given limited diagnostic and treatment capacity and especially the high and highly variable transport times, there is no assured access to hospital-based advances in obstetric practices that have greatly improved maternal, fetal, and neonatal outcomes of unexpected obstetric complications and emergencies over the past century. The implication is clear and unfortunately stark: Any claim by an attendant to planned home birth to be providing scientifically and clinically competent obstetric services is altogether implausible.<sup>29</sup>

The second commitment of the ethical concept of medicine as a profession requires healthcare professionals to protect and promote the health-related interests of patients as the primary concern and motivation, keeping self-interest systematically secondary. The inability to provide scientifically and clinically competent obstetric services in the home setting of planned home birth means that it is not possible for this commitment to be met. This conclusion also has a clear and, unfortunately, stark implication for attendants at planned home birth: they cannot plausibly claim to be acting primarily in the health-related interests of pregnant women, fetuses, and neonates.

These two implications of the new data analysis, we freely admit, are jarring. Together these two implications support a third clear and, unfortunately, stark implication: no one who attends a planned home birth can with scientific, clinical, and ethical justification claim the title of being a “professional.” This applies equally to physicians, certified nurse midwives, and those who represent themselves as professional or licensed midwives. Because it is not justified to describe attendants at home birth as professionals, no matter their training or experience, neither the pregnant woman nor the neonate can justifiably be referred to as “patients.” The pregnant woman becomes merely a client in a contractual, not professional, relationship. This is the nature of the nonprofessional relationship that results from the rights-based reductionist model of obstetric ethics. There are associations of professional midwives and they have codes of ethics.<sup>30</sup> Having such a code is usually one of the defining features of a profession. This is not the case

for code of ethics of associations of attendants at planned home birth. These codes of ethics cannot plausibly be represented to pregnant women or to the public as professional codes of ethics.

### PROFESSIONAL RESPONSIBILITY AND HOSPITAL BIRTH

The professional responsibility model of obstetric ethics has important implications for obstetric practice. First and foremost, when a pregnant woman is transported to the hospital from a planned home birth, she should receive uniformly excellent obstetric care. The second component of the ethical concept of medicine as a profession requires the entire obstetric team to focus on the patient and not themselves. This means that no judgmental attitudes should be cultivated and no judgmental statements ever be made.<sup>31</sup> Because they would be self-indulging, such attitudes and statements would be patently inconsistent with professional responsibility.

The professional responsibility model also calls for continuous enhancement of the organizational culture of hospital-based obstetric care. First and foremost, the professional responsibility model calls for an organizational culture of safety and prevention of clinically unnecessary interventions.<sup>32</sup> Patient safety has become the paramount goal of hospital-based obstetrics over the past decade. This change has required reforming organizational culture and includes the adoption of team principles and safety drills.<sup>33</sup> Adopting a comprehensive safety culture reduced the rate of cesarean delivery.<sup>34</sup> Adopting a comprehensive safety culture has become an important means for responding effectively to the concerns of pregnant women about excessive obstetric interventions in the hospital setting. These improvements implement the first commitment of the ethical concept of medicine as a profession. The majority of these safety goals cannot be satisfactorily implemented at a planned home birth. While the team concept in the hospital includes multidisciplinary members, such as certified nurse midwives, nurses, anesthesiologists, pediatricians, and obstetricians, there is no team concept at a planned home birth. At a planned home birth there is almost always only one attendant assisting the pregnant woman with her delivery. As a consequence, team care cannot occur, much less become a component of planned home birth, which is not compatible with quality obstetric care.

The second commitment of the ethical concept of medicine as a profession requires the creation of an organizational culture of compassion that sup-

ports the preferences of pregnant women throughout their pregnancies and aims to maximize a home-like setting in the hospital. For example, there should be self-conscious, deliberate efforts to create a quiet setting on labor and delivery and postpartum floors.<sup>35</sup>

### CONCLUSION

Planned home birth in the U.S. is not clinically or ethically benign and is not consistent with professional responsibility to and for pregnant, fetal, and neonatal patients. Obstetric healthcare associations should neither sanction nor endorse planned home birth. Instead, these associations should recommend against planned home birth. Obstetric healthcare professionals should respond to expressions of interest in planned home birth by pregnant women by informing them that it has significantly increased, preventable, and clinically unnecessary perinatal risks, by recommending strongly against planned home birth, and by recommending strongly for planned hospital birth. Obstetric healthcare professionals should routinely provide excellent obstetric care to all women transferred to the hospital from a planned home birth. It is incompatible with the ethical concept of medicine as a profession for any attendant to planned home birth to represent himself or herself in any way as a healthcare professional.

The professional responsibility model of obstetric ethics requires obstetricians to address and remedy the legitimate dissatisfaction of pregnant women with some hospital settings. Creating a sustained culture of comprehensive safety, which cannot be achieved in planned home birth, informed by compassionate and respectful treatment of pregnant women, should be a primary focus of professional obstetric responsibility.

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### DISCLOSURE

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